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PSYCHOTHERAPY
ITS USES AND LIMITATIONS

BY

D. RHODES ALLISON
M.D., M.R.C.P.

AND

R. G. GORDON
M.D., D.Sc., F.R.C.P.

GEOFFREY CUMBERLEGE
OXFORD UNIVERSITY PRESS
LONDON NEW YORK TORONTO
1948

OXFORD UNIVERSITY PRESS
AMEN HOUSE, E.C.4
London Edinburgh Glasgow New York
Toronto Melbourne Cape Town Bombay
Calcutta Madras
GEOFFREY CUMBERLEGE
PUBLISHER TO THE UNIVERSITY

PRINTED IN GREAT BRITAIN BY
MORRISON AND GIBB LTD. LONDON AND EDINBURGH

PREFACE

In recent years the art of Psychotherapy has grown up. From small beginnings when it was the object of suspicion if not derision it has developed to the stage when the public expect much of it and even the most conservative of medical practitioners accept it as an essential part of therapeutic procedure. So rapid, however, has been its growth that even its experienced practitioners are not quite sure of the extent of its present province and what may be expected of it in the future. As to the lay public it is confused by old claims some of which have had to be abandoned and by new adventures into what is now familiarly, but rather vaguely, referred to as psychosomatic medicine. Meanwhile the rank and file of the medical profession are hard put to it to know what can be done by psychotherapy and what cannot. They are apt to assume that it can or ought to be able to cure all sorts of mental illness, while the expert knows that it cannot. On the other hand, when the expert suggests that the treatment of many conditions hitherto supposed to be entirely within the field of the general physician or surgeon, would be much better referred to the psychotherapist the ordinary medical man feels bewildered. The medical student acutely conscious of the importance of " the mental side of medicine " finds it difficult to obtain definite directions.

With the end of the second world war the authors thought that the time was ripe to examine the whole field and try to assess the proper rôle of psychotherapy in modern medicine and to do something to define its legitimate scope and its undoubted limitations. They have made no attempt to describe the different methods of psychotherapy, there is literature enough and to spare on the subject. They have sought merely to indicate to the student and the practitioner the sort of case in which they may expect help from the specialist in this form of treatment and where he is unlikely to be of any assistance. They have tried to point out how without special knowledge the physician and the family

doctor may often help the patient to conquer his disease by maintaining his courage and morale and have urged the necessity, if medicine is to progress, that an end should be made to suspicions and rivalries and that all branches of medicine should combine to fight disease in a team which can deal with both psyche and soma with individual and environment, all of which indeed are indivisible.

D. R. A.
September, 1947. R. G. G.

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CHAPTER I

THE DEVELOPMENT OF PSYCHOTHERAPY

SINCE the time of Hippocrates and before, all doctors and healers have practised Psychotherapy. Before the rise of scientific medicine successes in treatment—and undoubted successes there were—must have been due in very large measure to the personality of the physician and his unconscious psychotherapy. It is difficult to believe that the fearful blunderbuss mixtures of toads' livers, the leaves of hepatica and such like can have had much therapeutic value or been more than placebos with a strong suggestive effect.

About a hundred or a hundred and fifty years ago, scientific physiology and pathology really began to undermine the pure empiricism of medical practice of the seventeenth, eighteenth and nineteenth centuries, which had continued to flourish in spite of the discoveries of Harvey and the Anatomists. It may be noted, however, that at that time physicians had the merit of treating the whole patient *secundum artem* however limited that art may have been. Later, bodily diseases and physical remedies occupied the centre of the field, and mental medicine lagged seriously behind. "Lunatics" were not treated, only confined.

It was not until Charcot, in his *Leçons de Mardi* in the 1870's, with his love of the dramatic presentation of disease, turned his own eyes and those of the profession as a whole, on the manifestations of hysteria, that a new interest arose in so-called nervousness and its different phases.

Although Charcot recognised that his patients were ill in mind rather than in body, he was more concerned with the symptoms of the disease and in their demonstration, than in its treatment. This aspect of the subject was left to the work of his followers and pupils, Janet, Dejerine, Dubois and above all Freud.

At the same time, the Nancy school of hypnosis arose and drew great attention to itself, by the success of the treatment provided, which benefited not only hysterical patients but also many who certainly had not been diagnosed as psychoneurotic, whatever the true nature of their disability might have been.

This gave rise to exaggerated claims for hypnosis as a therapeutic agency, and for a time it was thought that it might prove to be an almost universally curative measure.

In the early days, hysterics were the chief group of psychoneurotics who began to be differentiated, on the one hand from cases of organic disease, and on the other hand from insane patients. The obsessional and anxiety neuroses were still either classified with the latter, or regarded as a natural affliction, which the friends and relations of the patients, to say nothing of the patient himself, had to tolerate as best they might.

Since hysteria, or rather the symptoms of hysteria, are largely determined by suggestion and removed by counter-suggestion, most of the early psychotherapists adopted hypnosis or other methods of suggestion as their stock-in-trade. Bernheim in France and Tuckey and Milne Bramwell in this country were the chief exponents of the exclusive use of hypnotism, and many others, such as Morton Prince and Freud himself, practised it extensively.

The Swiss psychiatrist Dubois, however, following certain lines laid down by Dejerine, sought to treat his psychoneurotic patients by what he called persuasion, using rational argument and forcing them out of their disabilities by the sheer weight of reason. This method undoubtedly owed much of the success which it enjoyed, to the forceful personality and convincing manner of Dubois, so that both suggestion and what was afterwards to be called transference came into the process of cure.

Dejerine used the method of persuasion, together with very careful and complete history taking, so that he was able to show to the patient the logical sequence of events which led up to his symptoms.

Janet used hypnotism, but also persuasion, open suggestion and very superficial analysis. His contributions to medical

literature, however, are distinguished more for clear and vivid clinical presentations, than for any striking contribution to therapeutics.

Freud, a fellow pupil with Janet of the great Charcot, returned to Vienna fired with interest in, and enthusiasm for, the diagnosis and treatment of the psychoneuroses, especially, like all his contemporaries at that time, of the hysteric. Working with Breuer he employed hypnosis for some time, but the real birth of modern psychotherapy took place when a hysterical girl under hypnosis recalled a psychic trauma, which had occurred in her childhood. This recall was accompanied by a marked emotional outburst (abreaction) with manifest consequent improvement of her condition.

From this observation arose the elaborate theories of Freud, the doctrine of the unconscious, and the theory of repression and the endopsychic conflict. This culminated in the conception of the struggle between the primary unmodified instincts (the id) and the so-called superego. This superego is built up of all the taboos and inhibitions of society, the dominance and mandates of parents, and whatever there may be of inherent moral impulses in the individual himself, co-ordinated so as to become a part of the mental furniture of the subject. As a result of this conflict, what Freud called the ego, the individual as he is constituted at the moment, tended to be crushed between the upper millstone of the superego and the uprush of the instinctive forces of the id.

The Freudian theories have been too often described to require recapitulation here. Suffice to say that, from the original abreactional revival of memory of the hypnotized girl, was derived the knowledge that disclosure of emotional material hidden in the unconscious part of the psychoneurotic patient's mind was therapeutically beneficial. From this, too, was derived the practice of psychoanalysis, with its insistence on the importance of transference and its resolution, with its technique of free association, and analysis of dreams, peculiarities of behaviour, phantasies and the rest.

Freud soon abandoned hypnosis, as too uncertain in its results and insufficiently controlled to serve as a basis for scientific investigation directed to the discovery and revival of these emotionally charged memories, similar to the one

upon which he and Breuer had accidentally stumbled. Further, he soon found that direct history taking, which disclosed material which the patient could easily remember, did not lead to what he wanted. He described the material which was therapeutically significant as unconscious, by which he meant that it was not normally within the reach of the voluntary memory of the patient. A special technique was required to reach these hidden memories, and he soon became interested in dreams as giving him indications of unconscious material. He in fact described dreams as the royal road to the unconscious. From the study of dreams, especially those of the psychoneurotic, he recognized several dream mechanisms, which disguised the 'complexes' which he wished to uncover. The most important of these was symbolism. He elaborated a list, of what he regarded as standard symbols, which were mostly of sexual significance. One of the most criticized parts of his work, has been the insistence of Freud, and still more of some of his followers, on the rigid interpretation of these symbols. This, his critics say, has resulted in a completely unwarranted attribution of practically all mental illness to conflicts in the sexual life of the patient. Also, they say that Freud, using his special interpretations, unjustifiably attributed a sexual significance to the behaviour of infants and children, which could be explained on much more orthodox lines and still explain the abnormal symptoms which were being investigated.

To supplement the technique of dream analysis, Freud devised the method of free association as a means of reaching unconscious material. Free association is an unrestricted and uncensored pouring out of all ideas coming into the mind of the patient while he was completely relaxed in mind and body. Again he interpreted some of this material by what many people regard as a too rigid system of symbolism; since he was investigating psychoneurotics, and especially hysterics, it was perhaps not altogether surprising, that he found that his researches led him almost invariably to conflicts in the domain of sex. Actually many clinical observers before Freud had attributed psychoneuroses to sexual disturbances and all experienced psychotherapists must admit that, at least in a large number of cases, Freudian interpretations

do fit the bill. Critical observers, however, who are not prepared to follow the master blindly, do not find themselves able to agree, when he deduces from his findings in hysterics, that all human behaviour depends on repressed sexual wishes or impulses, even though these are declared to be unconscious and therefore not under the control or even within the knowledge of the individual. It is probable that the insistence of Freud and his followers that the mental processes of those who are mentally ill have universal validity in explaining the behaviour of normal human beings, has done more than anything else to discredit his theories.

It is quite impossible in the space at our disposal to discuss the further developments and elaboration of Freudian theory, but it has developed into a very complicated doctrine, which claims validity in almost every sphere of knowledge.

The important thing from the point of view of this book is that a system of therapy, which is called psychoanalysis has been developed by the Freudians, and it should be noted that this term psychoanalysis should only be used to denote the therapeutic methods of this school. The followers of Freud claim that their method is the only scientifically systematized scheme of psychotherapy and that it can readily be taught to those who are willing to submit themselves to the long course of study which is necessary. This training includes a psychoanalysis of the student himself, whereby he learns to appreciate the mental mechanisms of his patients and gets rid of the blind spots in his own mind which are due to his own unconscious conflicts. Bernard Hart has likened this training of all psychoanalysts by a personal analysis to the process of putting a number of things through a mangle, whereby they would all come out flat and so all alike, but the psychoanalysts would certainly repudiate this criticism.

That certain patients are suitable for treatment by the psychoanalytic technique, is unquestionable, but that all psychoneurotic patients, let alone those suffering from other forms of mental illness, are benefited by this method, has certainly not been proved. Many competent practitioners would in fact strenuously deny such a contention. No doubt it was the realization that psychoanalysis was not of universal

efficacy, that led some of Freud's followers to break away from him and elaborate theories and techniques of their own. Many of these theories and methods although founded on Freud's teaching eventually differed very considerably from the original doctrine.

By far the most significant of these apostates was Jung who, while adopting very similar methods of free association and dream interpretation to those of Freud, came to very different conclusions. His approach to the interpretation and correct explanation of the genesis of the psychoneuroses, was more philosophical and less materialistic. His somewhat involved and obscure theories are more difficult to follow for the average student. He does not insist so rigidly on a pansexual interpretation as did Freud and does not consider that repressed incidents in early childhood are the only significant factors in the origins of the psychoneuroses.

He maintains that the way in which the patient is meeting the present situation and is preparing to meet the future, may also be of great importance, both in respect of the origin and the course of the illness. He defines the mental illness as the resultant of these factors and of his previous mental make up. This make up depends largely on the contents of the patient's unconscious, but he does not think that this unconscious is entirely personal. By this he means that the product of the incidents and attitudes related to the patient's own life history are not the only significant unconscious material, but that it also contains archaic emotional and thought processes, which are part of what he calls a universal unconscious, which is somehow inherited by everyone.

Many of Jung's critics find this conception of the universal unconscious vague and unsatisfying, as it is not made clear whether this is transmitted by direct inheritance, and if so, how, or whether it is acquired as part of the general social heritage. It is on the basis of this theory however and the doctrine that the conscious and unconscious minds are complementary to each other, that Jung has worked out his valuable classification of psychological types. He believes moreover, that in the treatment of mental illness, not only is analysis necessary, but also some degree of psychological synthesis, before such treatment can be regarded as complete.

Another important apostate from the Freudian school was Adler. His treatment is much more didactic and educational than that of either Freud or Jung. Because, on the whole, his theories are more simple and more orthodox and his therapeutic measures allow more active intervention on the part of the therapist, his teaching has attracted more adherents than many people consider it deserves. Adler based his theories of psychoneurosis on the conception of an inherent inferiority of the whole personality, or of certain organs. The patient is supposed to compensate for this by developing a will to power. This striving towards perfection in themselves and dominance over others leads patients to reach out for false aims in life and impossible standards. In many cases it is possible to interpret the behaviour of the patient either on Freudian or on Adlerian lines according to the inclination of the physician. This has led to confusion, but whether the patient is supposed to be seeking an outlet for his sexual impulses or for his personal aggressive impulses, the results may be very much the same, and if he can be led into more socially desirable behaviour his general adjustment will be improved.

In treatment, Adler employed very little free association or analysis. He depended more on teaching his patients to abandon their false aims and formulate better ones, reverting almost to the persuasive technique of Dubois and Dejerine. He paid much less attention to dreams and the associations connected with them than did Freud and Jung, since he laid much more emphasis on the future than on the past, and indeed he paid comparatively little attention to unconscious material.

The description given above of the work of the three great masters of mental analysis is admittedly grossly inadequate, but such a vast and diversified literature has been produced in all languages, some of it highly technical and some popular, that the serious student should have no difficulty in mastering one or all of the theories and, if he seeks experience from the clinical treatment of patients, the techniques required also.

In the years immediately before the war of 1914–1918, Freudian doctrines had been formulated, but were only known to comparatively few, and still fewer understood them or were

competent to use them in practice. They had, however, already aroused considerable opposition, largely on moral and aesthetic grounds, rather than on scientific argument. During this war the occurrence of large numbers of cases of ' shell-shock ' and the discovery that these were due, not to physical injury, but to emotional disturbances, focussed public attention on the psychoneuroses and their treatment. Critics of the Freudian school had previously been comparatively few in number and with a few exceptions reasonably restrained, since they did not pretend to know much about the subject, and in any case the demand for such treatment was comparatively small. With the increased incidence of psychoneurosis due to the war, however, and the public demand for its treatment, a flood of criticism descended on the devoted heads of the exponents of psychoanalysis. Journalists, clerics, surgeons, all sorts of people, who knew little about clinical psychology or mental disease, vied with each other in the violence of their destructive criticism, while others maintained that the key to the future health, happiness and peace had been found. The virulence of the abuse and the ecstacy of praise was in strict proportion to the ignorance of the subject about which these protagonists were talking.

The inevitable result of this state of affairs was that reasoned criticism was stifled and the psychoanalysts closed their ranks, in some cases exaggerated their claims and, as a defensive measure, insisted on a near approach to infallibility for their methods. Whether post or propter, it was only after the publication of the report of the committee appointed by the British Medical Association to investigate the claims of the psychoanalysts that a change took place. This committee sought to present a sane estimate of the successes and limitations of the psychoanalytic school. After this passions started to die down and a tolerant and constructive attitude began to be taken towards psychoanalysis in particular and psychotherapy in general.

Unfortunately, in closing their ranks against the howling mob of uniformed critics, the psychoanalysts (the followers of Freud) and the followers of Jung and Adler, became less tolerant of each other, as well as of the ill-informed public, and the rival schools of mental analysis seemed even more

bitterly opposed, than were any of them to the philistines who abused all the analytical schools impartially.

In the early twenties of this century therefore, the public was faced with the unedifying spectacle of various bodies, who should all have been striving to advance the study of mental disease and to ameliorate the lot of the psychoneurotic glaring at each other with intense jealousy, making far too sweeping claims for themselves, expressing contempt and disparagement of each other and refusing to co-operate in any way. At the same time, various free lance psychotherapists baited the principal schools and built up, what were too often wild theories, on a totally insecure basis of ill-digested material and inadequate experience.

Meanwhile, some of the general public took up analysis with a misguided enthusiasm and were led to entirely erroneous interpretations and false annunciations of the original theories. Others continued to belabour those who professed these doctrines with prejudicial abuse which they fondly imagined was criticism.

This state of affairs led to an unbelievable lack of co-operation. Analysts even denied the advisability of proper physical examination of their patients, while general physicians would state publicly, with every evidence of horror, that such and such a psychotherapist had been caught using drugs. Apparently such people were quite unmindful of the fact that it was their duty to treat their patients by every means which seemed likely to benefit them, and not to use them either as laboratory animals or as a controversial weapon.

Gradually, however, constructive work was again undertaken and theories were modified in accordance with the inexorable pressure of new discoveries, and accumulated experience. The public learnt or perhaps it would be more accurate to say is learning to trust the psychotherapist as a reliable and conscientious physician of the mind, who will not abuse his position or seek to dominate the soul of his patient, as Trilby's was supposed to have been dominated by Svengali.

The public also realized that, although psychotherapy had often to concern itself with sex, its object was not to lead patients into horrific depths of immorality, or to titulate their less respectable desires and phantasies.

On the other hand psychotherapists themselves are beginning to recognize their limitations, and no longer claim to be miracle workers. The public moreover, are no longer expecting these miracles to be worked by them and, if the hoped for result is not achieved, are prepared to allow that the psychotherapist has done his best.

Since this more reasonable attitude has been adopted by all concerned, many more doctors have taken an interest in psychological medicine and there is a very rapidly growing demand for their services.

The medical schools however, are for the most part still lagging sadly behind the demands of their students for more up-to-date and thorough training in the mental side of medicine. Actually a great deal more will have to be done, for, though many more are trained, the demand for their services is increasing more rapidly than it can be met.

The 1939–1945 war found psychotherapists faced with the alternatives of farming out a great deal of their work to less well qualified auxiliaries or drastically revising their methods, so that the length of time taken to treat individual patients might be materially reduced.

It has probably been the dream of every busy psychotherapist to invent a method of collective psychotherapy, so that many patients could be treated at once. However, although claims have been made, they have not met with ready acceptance. The patient who requires psychological treatment, remains an individual problem which is bound to occupy a great deal of the physician's time, even though this has been considerably reduced by improved methods and better understanding, from the six hours per week for from two to five years which was the original estimate of the Freudians.

Since 1939 psychotherapists have done much, but they are constantly being called upon to do more. It is very necessary therefore, that they should recognize their limitations and that the doctor not engaged in this speciality should learn which patients are worth the expenditure of a lot of the specialist's time and which do not repay prolonged endeavour. Considerable advance has already been made by psychotherapists in discriminating which may benefit by short or

even collective methods of treatment and which require the old discipline of prolonged and deep personal analysis.

The present book seeks to formulate the problems raised by these present circumstances and to find some sort of solution. It seeks to review all the different classes of patients who may present themselves for psychotherapy, and to help the physician to differentiate between those who present mental symptoms and who can really benefit by psychotherapy, and those who present very similar symptoms or diseases, which must be recognized as not amenable to this form of treatment, though they may be treated by other methods.

Conversely, however, it must be recognized that there are many patients suffering from illnesses which appear to be bodily in origin for whom psychotherapy can assist or even displace general medical treatment.

Finally the problem must be faced, as to how psychotherapy can best be organized to give the most favourable results, with the greatest economy of time and effort, and how all concerned may most efficiently get together to make the patient a more healthy and sane citizen with a positive health both of mind and body.

CHAPTER II

PSYCHOTHERAPY IN THE TREATMENT OF THE PSYCHONEUROSES

THE most significant role of psychotherapy is to be found in the treatment of the psychoneuroses. If this is to be understood an attempt must be made to formulate a precise definition of what is meant by the designation psychoneuroses. The following may serve :

> The psychoneuroses are those mental illnesses and abnormal reactions, which owe their origin to emotional traumata or to the acquisition of wrong attitudes to life resulting from emotional disturbances to which the individual has failed to make a successful adjustment.

This definition implies that the factor of inherent disability is minimal and that the illness has originated mainly from events or situations impinging on the individual during his lifetime. From this theory of the psychogenesis of the psychoneuroses follows the claim that psychotherapy and especially mental analysis, if sufficiently skilled and if it is persisted in until the whole of the emotional life of the patient is explored, should cure all cases of this type of mental illness.

That this universal cure does not always pertain in practice is only too obvious, but it is a healthy and, it is suggested, a proper attitude for the psychotherapist to take, that he ought to cure his patients and if he fails to do so, the failure is due to his own lack of skill or perseverance. In fact unless he takes this attitude, he is unlikely to have much success at all, since success in treatment depends in large measure on confidence in success. Moreover, if he is too ready to throw the blame for difficulties and obstructions in treatment on the patient, he is almost certain to fail.

As Freud has rightly pointed out, the basis of all successful psychotherapy, whatever method is used, is the proper management of the transference. By transference is meant the establishment of emotional rapport between patient and doctor. If the doctor has no confidence in success, then the patient will not have confidence in success, and unless both have such confidence, success will not be obtained. A mutual confidence in success, however, between patient and doctor is not enough, for this transference not only can be, but is, in many cases, negative as well as positive, during certain phases of the treatment. Negative transference (hostility of patient to doctor) is in a large number of cases, an unavoidable incident in the course of treatment, since the trouble of the psychoneurotic is frequently based on the fact that he feels hostility to one or other of his nearest relations, and in treatment the psychotherapist is identified with and takes the place of that relative. It is the business of the psychotherapist in the course of treatment to resolve this negative transference and to convert this hostility into trust and even affection, which is the natural and basic feeling of the patient towards the relative whom the psychotherapist represents. He cannot leave matters here however; he must then resolve the positive transference, so that the patient can stand on his own feet, independently of the physician, with his emotional capacities free to form an attachment to a suitable mate or friend as the case may be, or to devote all his energies to his life work whatever form it takes.

In order that an emotional adjustment may be brought about through the transference, the patient must be given an understanding as to how his illness came to pass and how he may readjust himself to the circumstances in which he finds himself.

Adolf Meyer has pronounced what seems at first sight to be a cynical aphorism. He says that when the patient and the doctor agree as to the cause of his illness, the patient is cured. By this he really means that the absolute truth of the story of the origin and course of the patient's illness is not of primary importance. But the patient's assent to some explanation should be obtained; he should feel that the whole picture fits together and in this way, incidentally, his face will be

saved, a most important part of treatment. This assent of the patient is essential and it must be emotional as well as intellectual, that is to say, the patient must feel with his whole being that the explanation is adequate; it is not enough that he should give only intellectual assent. No doubt this agreement and the consequent cure will be all the more sure, if the story which has emerged in the course of the treatment is actually correct. In practice, however, this does not always matter so long as the patient feels satisfied, for this satisfaction will bring about a resolution of the primary instability which underlies all psychoneurosis. This instability is due to the loss of the sense of security. If the patient feels that the story explains all his troubles, this means that he not only understands the origin of the complex emotional disturbances which have been responsible for his ill-health, but this understanding enables him in theory at least to accept and master the situation. Only then can he make a new start in life, secure in the feeling that he has cast off his burden of the past, like Christian at the gates of Paradise. Admittedly if the burden has been attached to him too long, if his powers of adjustment have become too limited and his character has become too fixed it may be very difficult or even impossible to loose his burden.

This is not the place to discuss either the clinical manifestations of the psychoneuroses or the various methods of psychotherapy. A vast literature has grown up on both these subjects and to go into any detail would swell this work out of all proportion to its object.

Suffice to say, that it is held here that the basis of all psychoneurosis is a feeling of insecurity with consequent anxiety. That the simple anxiety condition is due to emotional conflict based on a faulty attitude to life. This conflict may have been started by some definite emotional trauma, as Freud taught in his early days. It is not the trauma, however, which is important. Indeed in many cases no single trauma can be specifically discovered. What matters is the attitude of mind induced by emotional disturbances, whether these comprise a major event or a series of minor difficulties. These difficulties and conflicts may or may not be associated with sex, but experience shows that they very frequently are,

especially with the earliest manifestations of sex emotion unspecifically directed as these are, to the individual himself, to near relations and to persons who may be of either sex.

The anxiety states may be divided into reactive anxiety and the true psychoneurotic anxieties.

In reactive anxiety the true cause of the trouble is in consciousness or very near it; the patient knows what he is worrying about, but is taking an exaggerated or disproportionate attitude towards it and is failing to take adequate practical steps to deal with it. There is very little doubt that in the majority of cases, this disproportionate anxiety is at least partially caused by a pre-existing sense of insecurity, and it is the task of the psychotherapist, not only to persuade or suggest to the patient that he should take a more reasonable view of the situation, and to help him to come to a decision as to what is the best course to pursue to remove the cause of the anxiety, but he also must investigate to what extent a previous sense of insecurity existed and on what it was based. Then by methods to which reference will be made directly, he must resolve and remove this so that the patient may meet the accidents of fortune more robustly and successfully.

Reactive anxiety is naturally common in times when society is unsettled; injury and illness of loved ones, non-existent homes, unsympathetic relatives, financial difficulties inherent in rapidly changing conditions, are all conducive to anxiety which is difficult to resolve. Too often the subject of such anxiety takes no measures to improve his lot, perhaps because he fears failure. He does not attempt to meet the crisis or to face inevitable loss, and here the understanding psychotherapist can do a great deal without complicated or prolonged treatment.

In the course of this 'first aid' treatment he will however have an opportunity of discovering how much underlying insecurity may exist, how far in fact he has to deal with a true psychoneurotic anxiety.

In true psychoneurotic anxiety the patient is not aware of the cause of his anxiety and he can no more tell what the real origin of the trouble may be, than can the psychotherapist before he begins treatment. He may think he knows why he is anxious, but it very soon transpires that this conscious

anxiety is not significant, and removal of its cause does little or nothing to cure the patient's mental illness. It is clear that the two types merge into each other and that only the extremes can be completely distinguished.

The causes of true deep-seated anxiety states are manifold and have been dealt with in great detail by many authorities. It is enough to repeat that they all would seem to result from a habitual attitude of mind, which involves a feeling of emotional insecurity. This is frequently due to a whole series of events and situations, which can be traced back step by step to a very early age.

Freud has suggested that the common fundamental basis is the oedipus complex, a hatred and jealousy of the parent of the same sex, amounting to a desire to inflict injury or mutilation. At the same time there is an affection for the parent of the opposite sex, so pronounced as to amount to incestuous physical desire. Both these emotional reactions are attended by a strong feeling of guilt, hence the conflict. Others have denied the existence of this oedipus situation even in the worst cases of psychoneurosis.

All those experienced in the analysis of the adult psychoneurotic must admit that the unmasking of this sort of situation, often in a very modified and attenuated form, is by no means uncommon ; but that it is always found even in the psychoneurotic is by no means certain, and that it is a universal experience is almost certainly untrue. What does seem much more fundamental is the feeling often dating back to early infancy that the patient has lost the parental, and especially the maternal, love and protection which is his birthright. It is right to say that this feeling of loss is more often a product of mistaken phantasy than the result of actual neglect or cruelty, though the latter may, of course, occur.

It is the duty of the psychotherapist to bring the patient to see that the loss has been more imagined than real, but that even if much loss of affection had been suffered, that situation which was of the very highest importance when he was a child, is not, and need not be felt to be, nearly so significant, now that he is grown up.

He must be shown that he has, or that he ought to have, outgrown the need for complete dependence on, and the

protection of, his parents and the home of his birth, and that he now should be standing on his own feet. Also, because he thinks, rightly or wrongly, that his parents let him down, it by no means follows that every one else will let him down, which is in fact what he is thinking. He must believe that he can and does have compensatory supports in wife, family and present friends.

In many cases it takes a long time and hard work to bring the patient to an opinion in agreement with that of the doctor, both as to the cause and significance of his troubles, and as to what his present attitude should be, but, as has been said, success in psychotherapy depends on the confidence of both the patient and the doctor that success can be achieved. If the patient does not believe at first that cure of his condition is possible, it rests with the doctor to use the strength of his personality to persuade the patient to believe in him and his power to make him better.

The psychotherapist may and generally does, have to assume the role of parent or friend who will not let him down, and on whom he can depend through the process of transference ; but the cure will not be complete until the patient can depend on himself, rather than on anyone who represents his parent. In other words he must grow up and become an adult, putting away childish dependences.

This state of simple anxiety may be overlaid. In extroverted, suggestible, non-critical people the anxiety may be converted into a hysterical symptom, especially if some mild physical disability co-exists, which serves as the basis for the suggestion that this disability is much more serious than it really is. This conversion gives the illness an air of respectability and objectivates what was previously an inexplicable subjective experience. Here, in the motor, sensory or visceral disability, is something which anyone can see and perhaps understand, and in any case is a very good reason in the eyes of the patient and probably in the eyes of his relatives, why he should be ill. It in fact saves his face for the time being at least. By thus being ill he gains, no doubt unconsciously and involuntarily, a very distinct advantage. He may avoid the effort needed to adjust to a situation, whether in war or peace, for which he feels inadequate. Or he may secure

revenge on a relation to whom he feels hostile, by making him, or more often her, look after him and wait on him hand and foot. Again he may gain the sympathy of someone who, he thinks, does not understand him or love him enough or pay enough attention to his difficulties, which he is sure are far greater than those experienced by anyone else. He may even hope to gain the sympathetic regard of the world in general for qualities which are only products of his own wishful thinking, a considerable balm to the feeble soul.

It would be quite unfair however, to imply that the patient does all this deliberately, however obvious the motive may appear to the onlooker. The true hysteric adopts this attitude quite unconsciously and would be rightfully as well as righteously indignant, if accused of conscious fraud and of deliberately gaining his ends by false pretences. His unconscious motive is given away, however, by the 'belle indifference' with which he regards his symptoms, however alarming they may seem.

If a hysterical symptom has not become too habitual by prolonged lack of treatment, or by wrong suggestions consequent on failure on the part of the doctor to make a correct diagnosis, it is fairly readily removed by counter-suggestion or by persuasive re-education; but, when the symptom has been removed, in most cases only the first step has been taken. It is certainly true that, especially in war cases, by the time the symptom has been removed the immediate crisis has been overcome or has passed away and the symptom having been removed and no longer necessary in the present situation, the patient is to all intents and purposes well. In practically all peacetime cases, however, and in a large number of war cases, the removal of the symptom will only unmask the anxiety, which then has to be treated by suitable analytic methods.

In the case of the introverted and frequently introspective type of individual, the simple process of converting the anxiety into a 'respectable' hysterical symptom from which he can obtain the advantages which he requires, will not serve. He sees through such a manoeuvre not only in others but also in himself. This does not mean that the hysteric could equally see through himself if he wanted to, because the introvert,

by reason of his constitutional make up, sees more deeply into his own personality than does the extrovert.

The intensity of the anxiety and feeling of guilt in such a person, however, may be so extreme, that it is no longer tolerable. In this case the emotion is displaced from a situation, which is of vital significance, to one which is, even to the patient, insignificant. This displacement gives rise to obsessive symptoms which may either be phobic or compulsive. Both of these are distressing in themselves but not as bad as the original situation. Although the patient realizes and will freely admit that it is ridiculous that he cannot enter a small room, or must go downstairs five times to see that the gas is turned off, it is quite impossible, or at least very difficult, for him to face the one or avoid the other.

The obsessive symptom is symbolical of the underlying conflict or of a manifestation of it. A patient has hostile feelings towards a parent or wife and finds himself harbouring phantasies of murder. Since the introvert is in any case, close to the world of fantasy and is never quite sure that what is phantasy at one moment may not be reality at another, his whole moral being, backed by the underlying affection for the relative which no doubt exists however much it may be overlaid by the secondary hate, rises in revolt. The conflict is intolerable, and therefore he protects himself by displacing the affect from the relative and developing a phobia for sharp knives or other lethal weapons.

The young girl brought up in a religious atmosphere, is assailed by sexual impulses which fill her with shame, fear and confusion. She partially, but only very partially, escapes from this intolerable situation, by developing a compulsion to utter obscene words while engaged in her religious exercises. This is indeed a distressing situation, but at least the words seem to be forced on her independently of her volition and she is doing her best to keep her mind pure by saying her prayers, so that her sense of guilt is mitigated.

Obsessions are notoriously difficult to treat. While these patients are often highly intelligent, so that they can follow and co-operate with the treatment, the anxiety which underlies the obsession is very intense and very deep seated, otherwise this critical and intelligent patient would not have developed

the obsession. The faulty attitude is ingrained and the situation is one which affects the innermost being of the patient, and the consequent insecurity and anxiety are therefore exceedingly difficult to remove. So much is this so, that some have thought that obsessional patients are psychopathic personalities with an inherent factor dominant in the genesis of their trouble. Probably this is not so in the psychoneurotic type of obsessional, but it should be remembered that patients suffering from early schizophrenia may develop obsessional symptoms and that for a time the differential diagnosis may be exceedingly difficult. It follows therefore, that some patients who are thought to be true cases of psychoneurosis are not so, but are in fact psychopathic personalities of the schizoid type, and the true diagnosis can only be established when the treatment or attempts at treatment have been in progress for some time. However, since psychotherapy has a limited place in the treatment of the schizophrenic, an early correct diagnosis is important, if the waste of much time and effort is to be avoided.

This may be a convenient place to point out that psychotherapy either along the same lines as are used for adults, or by the more modern methods of play therapy, are usefully employed in the treatment of delinquency, especially in childhood and adolescence, as well as in other emotional difficulties and maladjustments of children. It is a matter of argument as to whether these behaviour disorders should be described as psychoneuroses or not, but if they are not full blown psychoneuroses, they are larval forms of this type of mental illness and the treatment of these maladjustments of childhood have a direct bearing on the prevention of subsequent psychoneurotic and asocial behaviour. It stands then to reason, that the earlier psychotherapy can be started the better, for, if only from lack of time, the faulty attitudes to life are not so deeply ingrained and have not become so habitual. Indeed it often happens that the environment of the child, of which the parent forms an important part, requires treatment or alteration more urgently than the child himself, for an unfavourable environment is the soil on which insecurity is based and flourishes. Once this has been put right moreover, the adaptability of the child is much

greater than that of the adult so that when obstacles have been removed he almost automatically readjusts himself.

There can be no doubt that the experienced psychotherapist is much more capable of giving sound advice as to how the environment should be treated or altered so as to give the child the best chance, than is anyone else. This is because he has all too often seen the regrettable results of the interaction of a similar environment with a similar child, in his more fully developed and older psychoneurotic patients.

Child guidance in which practical psychotherapy is developed in its widest and fullest extent and operates at a stage of life at which it has the best chance of success, is therefore of the highest importance and should be available in all areas and for all classes.

Psychotherapy, or rather the wisdom and experience of psychotherapists, has a place in the resolution of marital and family difficulties, although no actual psychoneurotic illness may have developed in anyone concerned. Nevertheless although no one may be ill, the unhappiness everyone experiences may seriously affect their efficiency and may well lay the seeds of future illness.

The secondary effects of psychoneuroses in the form of psychosomatic illness and visceral neurosis are dealt with in chapters IV and V and need not be referred to here.

It will be seen from what has been said that psychotherapy is the sheet anchor in the treatment of the various disabilities referred to in this chapter. What form this psychotherapy may take, whether persuasion, suggestion, the various analytic treatments prescribed by Freud, Jung, Adler or others, or by such special procedures as play therapy will depend on the age, intelligence and circumstances of the patient and on the taste, special aptitudes and training of the psychotherapist. In the last instance however, success or failure will depend on the personality of the therapist and the success he enjoys in establishing and managing the transference with the patient.

Some therapists are only able to establish transference in a satisfactory way with the few, others with many ; some can readily establish transference, but fail when it comes to the management of this transference. Success will only come to those, moreover, who can approach their problem with an

open mind, without prejudices, moral or intellectual, and above all to those who understand and can control their own emotional reactions. The psychotherapist must not therefore be psychoneurotic himself or, if he is, he must be treated before he treats others.

The Freudians say that no one is free from conflicts and inhibitions and that therefore, everyone is an actual or potential psychoneurotic. They therefore recommend that everyone must subject himself to a personal analysis, before he undertakes to analyse anyone else. Whether this is advisable in every case or not is a matter of opinion, but that the psychotherapist must have insight and knowledge of himself is essential, otherwise he may land himself and his patient quite unconsciously in a worse emotional morass than that from which he is trying to rescue him. Certainly a personal analysis is a very good way of obtaining the necessary self knowledge, but the further contention that is made by some psychoanalysts that a personal analysis automatically qualifies the analysand to become an analyst is very much more open to dispute.

Even when he is suffering from a psychoneurosis the patient must be considered as a whole. Therefore, physical or pharmaceutical remedies should not be neglected or refused. It is essential, however, that they should be recognized both by patient and doctor for what they are in the treatment of these cases, namely adjuvants to be used in the removal of symptoms, and not as specific remedies in the cure of the disease.

Used in this way, hypnotics may be of the greatest service, for it often happens that the sleepless patient cannot co-operate in his treatment until he regains the habit of sleep.

In the treatment of certain hysterics, whose disability is suggested by mild degrees of somatic diseases, the treatment of these, at the same time as psychotherapy is administered, may be extremely useful. Massage, heat and injections for a fibrositis underlying an hysterically exaggerated pain or limp, carminatives for dyspepsia, laxatives for constipation, are all, not only permissible, but very valuable, provided that both the patient and the doctor are fully assured that they are no more than symptomatic remedies, which make the discipline

of the real treatment more easy to carry out and more successfully accepted.

In the same way, physical remedies, such as hydrotherapy and the old fashioned stand-by, change of air and scene may be useful, though it is probable that they are seldom necessary. It should be remembered also that the psychoneurotic, however far and however fast he runs away, takes himself and his illness with him. Unless and until he, with the help of his doctor, tackles what lies within himself, he will never escape from the toils.

Occupation for the psychoneurotic is absolutely essential, except perhaps in the very acute stages of his illness, and most psychotherapists consider that these patients are best treated as out-patients, and while they are at work. If this is not possible, then occupation and rehabilitation, so that they have something else to do than think about themselves, is very necessary. In devising this, the help of the occupational therapist and the rehabilitation centre may be of the greatest value, since this occupation must have the constructive object of refitting the patient for life by encouraging his creative impulses, and must not be merely a way of passing the time.

CHAPTER III

TEMPERAMENTAL INSTABILITY

A DIAGNOSIS which has been much in vogue since the beginning of the world war to describe a soldier who seemed too unstable to fit into the military machine, has been 'Temperamental Instability'. Doubtless in the hands of some psychiatrists and others this has become something of a wastepaper basket into which unsuitable material has been thrown when the exact diagnosis of the case has not been determined.

It is an easy criticism to say that such a practice is reprehensible, but anyone with psychiatric experience must realize that there are quite a number of patients who do not present a clear cut picture of any single mental disease enumerated in the official nomenclature which had to be adhered to in the services and who seem to exhibit unsatisfactory reactions of different types in different circumstances. It often requires prolonged acquaintance with such individuals before it can be determined what constitutes their specific pathological reaction, and therefore in what particular category they should be placed. In some cases a certain amount of tentative treatment may be necessary to ascertain their power of insight and their fundamental desire to adjust to their environment before it can even be decided whether their reactions are psychotic in nature or are more properly to be regarded as psychoneurotic.

Under service conditions such elaborate and prolonged study of the individual patient was generally impossible, but even in the most ideal circumstances of leisurely psychotherapy it is difficult enough quickly to arrive at a specific diagnosis. A certain number of individuals will be found who do not seem to be true anxiety cases, nor are they true hysterics, obsessionals, schizophrenics or cyclics, and in whom no organic physical basis of illness can be found. These people nevertheless seem

incapable of adjustment and are in consequence truly sick folk. They are in fact psychopathic personalities (see Chapter XI) and perhaps should not be considered separately from these.

It is this group of people who may properly be described as temperamentally instable. All through their lives they have experienced difficulties, in spite of adequate intellectual capacity and reasonable physical constitution. In addition to anxiety they generally give a history of one or other of the manifestations of psychogenic somatic disease or else one or more of their immediate family have suffered from such illnesses. In these cases even deep analysis may fail to elucidate any therapeutically significant psychic trauma or abnormal emotional situation. Even if such events or situations are disclosed and their nature and apparent significance brought into the patient's consciousness, the result is not so favourable as the analytical psychotherapist expects. While it may be held to be a weakness for the psychotherapist to fall back on a congenital lack of stability to explain the failure of his treatment, that such is the true explanation in some cases seems to be certain. Admittedly all psychotherapists must be very chary of accepting this easy explanation of his patient's symptoms without careful examination both physical and psychiatric, yet it is equally foolish to state dogmatically, as some do, that no such state of affairs exists, and that to diagnose temperamental instability is nothing but the mark of diagnostic inefficiency and of therapeutic laziness.

If it is admitted that such a condition exists, it may be assumed that there is some inherent defect of stability, and this defect must be in the higher control of the affective autonomic apparatus.

The close connection between emotional experience and visceral disturbance is a common-place observation, and it is therefore not surprising that this class of temperamentally instable people should suffer from the so-called visceral neuroses. This connection is discussed elsewhere.

This group of temperamentally instable persons, just as they present variable physical syndromes so they present atypical psychical syndromes, and their emotional reactions

and behaviour under varying conditions are unpredictable. All that can be said is that those reactions tend to be unexpected and inappropriate.

It is interesting to observe that such people may behave quite well in trying circumstances, such as bombing raids, but express great concern over purely problematical dangers from a sea voyage or an unhealthy climate.

For example a soldier had a good record in a series of blitzes in England, but on going out to West Africa developed a violent phobia of insects and of thunderstorms while even the mention of blackwater fever threw him into a state of helpless despair. His whole life history at school and at work had been characterized by an analagous state of unpredictable emotional reactions and his autonomic responses were erratic and inappropriate.

Such patients are often of high intellectual and artistic capacity and can not only hold their own in the field of knowledge but are able to understand and appreciate the nature of their disability; they are not however thereby enabled to control and regulate their emotional reactions.

The condition is analagous to that met with in so many young people in relation to sex, though, in their case, experience and growth of general capacity as a rule results in complete adjustment later in life. These adolescents know everything there is to know about the facts of life and yet this knowledge seems to help them not at all in the control and organization of the admixture of fear, curiosity, and physical desire which assails them in relation to their sexual functions.

With the temperamentally instable, such a state of mind is habitual and permanent and is characteristic of them more or less from the cradle to the grave, not only in relation to sex but to all other emotionally charged situations.

For such people the powers of the psychotherapist are limited and he must not expect more than a partial success. Deep and prolonged analysis may seem to do good because of the positive transference which persists during the analysis; but as Freud has said the essence of successful psychoanalysis is the ultimate resolution of the transference and this is just what the analyst cannot achieve with these patients. He must in many cases choose between remaining as a

permanent director as is necessary for the psychasthenic (see page 122), or abandoning his patient to his fate, sometimes in a worse condition to meet it than when he started.

What to do with such people is therefore a very serious problem. They are difficult to diagnose from the true psychoneurotic until both doctor and patient are deeply involved in a course of treatment with all the consequent emotional entanglements. Perhaps the right course can only be determined by the intuition of the therapist and he may decide that a patient is truly temperamentally instable without being able to give any valid explanation of his decision. If he is right in his opinion he will have saved both the patient's time and his own. If he is wrong he may have deprived a patient of the chance of cure which intensive treatment might have afforded him.

If the temperamentally instable patient can be pinned down to accept effective treatment it is undoubtedly of use to give him some insight into his condition to show him his limitations, and to try to teach him and to help him to adjust his life accordingly, but great care must be taken to regulate the transference. Psychotherapy after the initial diagnostic analysis should for them be didactic and educational. An effort must be found to discover what special capacities or talents the patient may possess and endeavour to allow him to use these either as an occupation or as a hobby. If this is successful it will give him a sense of security and efficiency which will help to stabilize him to some extent. Too often however these patients want to do everything except what they are doing or have an opportunity of practising, and so all efforts to help them are discarded before they have a chance to become effective.

While the main lines of treatment should be directive and educative, in certain patients it may be useful to exhibit certain drugs or physical methods of treatment such as hydrotherapy designed to have a sedative effect on the overactive autonomic system but only if the doctor *and* the patient are fully cognisant of what is being done. The patient should not be allowed to think that his ' disease ' is being ' cured ' by magic potions or strange diets or disciplines ; his disability will not be cured by these or any other remedies and his

discouragement and his sense of insecurity will only be increased by their failure. Such methods of treatment may make life more tolerable, but that is all they will do, and all they are meant to do.

Similarly the various psychosomatic symptoms from which such patients suffer, the prurigos, the effort syndromes and the visceral spasms may or may not be helped by pharmaceutical preparations or physical remedies, but these must not be considered as anything more than adjuvants used in the general management of the case.

Above everything the patient, although he is manifestly far from well, must never be allowed to think that he is suffering from ' a disease '. On the other hand it must be admitted that he is suffering from a disability and it certainly does no good to tell him or even to suggest to him that it is all imagination and that he could help his condition if he tried ; that if only he would ' pull himself together ' he would be all right.

Once the diagnosis is established it must be explained to him that no two people are exactly alike, some have red hair, some have black, some are fat and some are thin, he is different from many people in being more emotionally labile and more sensitive to changes in the environment than are others. This, it should be explained, is not entirely disadvantageous as he may be more artistically sensitive, better able to ' see round a corner ' than his more placid neighbour, yet it does have disadvantages of which he is only too well aware. He must be warned against taking pride in being ' highly strung ', and he must be prevented from pitying himself as being too sensitive to live in this hard world. The connection between emotional and autonomic instability must be explained to him, so that he has an insight into and understands the nature of his physical symptoms. He must be got to co-operate with his physician in planning his existence so that his capacities are used to the best advantage, and the effects of his disabilities mitigated so far as possible ; his environment should be reasonably stable, and he must be taught to use such remedies as are prescribed in a sensible and proportionate way.

CHAPTER IV

PSYCHOSOMATIC CONDITIONS

A GREAT deal of attention has recently been paid to Psychosomatic medicine and it is very generally agreed that many physical syndromes are due in whole or part to emotional disturbance. It has of course long been recognized that hysterical symptoms—the so called functional paralyses, hyperkineses, anaesthesias and hyperaesthesias and visceral disturbances such as train sickness, enterospasm and to a large extent anorexia nervosa are conversions of anxiety states and can be cured with greater or less difficulty by adequate psychotherapy. It has likewise been recognized that certain symptoms and syndromes such as epilepsy and the vomiting of pregnancy may be much increased in frequency and severity as a result of anxiety and its conversion into symptoms which serve an end, of which the patient is unconscious or which the patient will not voluntarily admit.

Psychosomatic medicine in its modern form is more concerned with conditions which, though originating from anxiety states through the disturbance induced by these on the functions of the hypothalamus and pituitary, and through the latter on the autonomic and hormonal activities, may in turn become irreversible and result in chronic ill-health or even the death of the patient.

A considerable literature has grown up on the etiology and diagnosis of these conditions, but all too little on their treatment. For example in Dunbar's [1] excellent survey of the literature only 11 pages out of 432 are devoted to therapeutic measures. It is obviously important for the purpose of this book to examine how far psychotherapy can alter the outcome of these conditions and bring about an improvement in the patients' health or even occasionally a cure of their illness.

[1] Dunbar, F. 1945. *Psychosomatic Diagnosis.* New York.

It may be said that psychotherapy of greater or less complexity will produce an improvement in any and every disease. For example, the proper psychological management of the rheumatic child or of the adult suffering from phthisis may make all the difference between success and failure in treatment. Even in ' straightforward ' infections much may be done.

A woman of 46 unmarried suffered from severe chronic anxiety with insomnia, nightmares and general lack of efficiency. She also suffered from a recurrent sinusitis which necessitated her admission to hospital every winter over a period of several years so that she had to regulate her programme to allow for this period of inactivity each year.

Psychotherapy of an extensive but not very intensive type was undertaken for her anxiety and extended over two years though after the first six months the treatments were infrequent as the patient went to live at a long distance from her physician. This treatment was very successful not only in restoring her sleep, efficiency and happy relations with her family and friends, but post or propter her sinusitis ceased and follow-up has shown that she has never had to have treatment for this since.

The conditions most commonly included in the category of true psychosomatic diseases are asthma, certain eczemas, hyperpyesis, duodenal ulcer and ulcerative colitis. In all these there is little doubt that an emotional factor is important in their genesis. As there is no real division between psyche and soma in the patient, all illness should perhaps be considered as psychosomatic, but this is making the definition meaningless. Unfortunately, even in the conditions enumerated above, by the time the patient comes under treatment, the disease process has so crystallized that his disease is classified either as physical or psychiatric. At this stage the prognosis may already be determined and the opportunity to alter the reactions of the personality whether mental or physical has passed. Present observations suggest that as the disease process progresses changes in somatic and character structure become simultaneously irreversible. The psychosomatic approach is therefore more effective early in the disease when there is less character rigidity and less structural damage. Unfortunately, too many patients have their first

opportunity for psychosomatic treatment when it is too late for such treatment to be of more than palliative value.[1]

Before proceeding to a consideration of the effect of psychotherapy on these particular disease processes it is important to appreciate some of the effects of emotion on the physiological processes of the body.

In an important article Wittkower[2] has given the results of his carefully controlled studies on the influence of emotions on the functions of various organs. His conclusions are as follows :

1. *Heart and vessels.*

The size of the heart can be influenced emotionally. Both enlargement and diminution of the heart shadow as shown by x-rays occurs to the extent of more than 1 cm. When the emotion has faded out the cardiac changes recede.

2. *Salivary secretion.*

An increase or decrease of secretion may take place but this is not determined by the type of emotional experience. Differences in composition of the saliva may also be found.

3. *Stomach.*

All possible variations of disturbed gastric secretory functions occur but seem to be determined more by the type of the personality subjected to the emotion than by its nature. In the majority of cases an increase of gastric tone occurs under emotional influence.

4. *Bile.*

Most emotions stimulate bile secretion but during anger the flow of bile is entirely, or almost entirely, inhibited.

5. *Blood.*

The leucocyte count can be altered by emotions, generally in the direction of an increase, more rarely of a decrease, without change of the differential blood picture. Serum calcium, potassium, chloride and water content can be influenced by emotion but fluctuations of the fasting blood sugar are within physiological limits.

[1] Dunbar, F., and Arlow, J. 1944. *Psychosom. Med.*, vi., p. 283.
[2] Wittkower, E. 1935. *Jour. of Ment. Sci.*, lxxxi., p. 533.

6. *Urination.*

Changes in the amount of secretion of the urine occur both in the sense of increase and decrease, but the changes occurring directly after the emotion were generally balanced during the course of the day.

7. *Thyroid.*

Under the influence of emotion the blood iodine may rise considerably; after the emotion has faded out the iodine level drops gradually, with individual variations, back to normal.

If such physiological changes are possible under the influence of short-lived emotional experiences, it is not difficult to understand that prolonged emotional disturbance may induce changes which are definitely pathological and which ultimately may become irreversible.

Bronchial Asthma—Asthma is, of course, only a symptom and not a disease, but the symptom complex which is generally supposed to be allergic in origin probably has a more complex derivation than a straightforward reaction to certain dusts or foods. It is well recognized that emotional states may have a dramatic effect both in determining the attack and relieving it.

It has frequently been observed that asthmatic students going into an examination hall are not infrequently handicapped by an attack under the influence of long drawn out anxiety. On the other hand one of us was driving with a distinguished physician who was notoriously afflicted with asthma. Just after a severe attack had begun, he started to descend a steep narrow Devonshire lane. To his alarm he discovered the brakes of the car were not working. With commendable skill he steered the car down the winding lane on to a straight level piece of road at the bottom. Here, though somewhat shaken by the fright he found he had no asthma. The adrenalin physiologically poured into his blood stream had relieved the spasm.

McDermott and Cobb investigated fifty cases of asthma, selected at random, from an allergy clinic. They found that twenty-seven had an emotional composition in their asthmatic attacks. Twenty reported that the first attack was emotionally

precipitated while thirty-one reported that later attacks were often emotionally determined. Thirty showed other psychoneurotic traits, usually of a compulsive character. With regard to treatment, it has been suggested that the various types of somatic therapy act only through their suggestive influence, but 54 per cent. of the 'non-emotional' group received more than slight benefit and only 20 per cent. were similarly affected in the 'emotional' group. Since the latter might be more suggestible than the others it seems probable that such somatic treatment does not only act by suggestion.[1]

The psychological treatment of asthma is more familiar than that of some other psychosomatic conditions, but the following case quoted from Alexander and French illustrates the sort of story which may underly this so-called allergic symptom.[2]

A recent graduate of a medical school, twenty-four years old, single, came for treatment because he felt unable to practise on account of severe asthma attacks. He had a history of asthma since the age of fourteen when he had gone on a diet and had reduced his weight from over 200 to 155 pounds. Four years before coming for psychotherapy, tests had found him allergic to beef, pork and chicken.

He was seen approximately once a week over a period of nine months with good therapeutic results. The therapist (a woman) was able, because of her previous knowledge of the fundamental dynamic structure of the asthmatic disorder, to direct treatment at once to the central problem—deep dependence on a mother figure plus the fear of becoming estranged from her by somehow offending her.

The patient's mother had died when he was three. Of this event he recalled only her leaving for the hospital on a stretcher, and crying as they took her away. The next six years the patient spent with an aunt and uncle, then returning to his own home when his father remarried. The patient was at first hostile to the stepmother, but soon became fond of her.

[1] McDermott, N. T., and Cobb, S. 1939. *Psychosom. Med.*, i., p. 203.

[2] Alexander, F., and French, T. M. 1946. *Psychoanalytic Therapy.* New York.

The patient expressed great disgust at the beginning of the treatment at his aunt's 'infantile greediness and obesity'; he remembered however, that as a child he had longed to be fat like her. This attitude towards his aunt's stoutness may be taken as indicating a relationship which later became plain—that his own obesity had served as a defence against the conflict arising out of his erotic attraction to the stepmother.

Almost immediately the patient developed a strong dependent attitude toward the therapist and wished her, like other women, to assume full responsibility for his behaviour, erotic or otherwise. Although this dependence was pointed out to him, the patient made no resistance. He was elated over his treatment interviews and refused to listen to any warning that resistance might come later. He was certain nothing could interfere with his friendliness toward the therapist.

The first time the patient came to an interview suffering from an attack of asthma, he attributed it to having had to hurry in the morning. In discussing it, he recalled his resentment at this aunt's attempts to keep him infantile, his anxiety when his uncle chided him for being snuggled too closely by his aunt, and his uneasiness with girls from the time he was six. He added that he was now conscious of the fact that he felt insecure when he was alone. The therapist had encouraged him to take a job to cover his expenses, and he said that the asthma attacks were severe whenever he was left alone there at night. It was suggested to the patient that his asthma might come whenever his dependence was threatened. The therapist indicated that since his attacks began at fourteen, she wondered whether the asthma had some relationship to impulses in him that might threaten a pleasant relationship with a mother-person. Immediately to this the patient asserted that his stepmother had been very young, voluptuous, and openly seductive with him. In the five years from the time he went to live with her until he was fourteen, the patient was often consciously aroused sexually. Then, wanting to become more attractive physically, he had reduced. Although from that time on he had attacks of asthma, he was no longer conscious of sexual feelings toward his stepmother.

Hostile dependence toward the therapist, however, was soon mobilized. When she refused to offer to intercede for him against recruitment, the patient's asthma became worse. When she continued to refuse despite his constant hints in this direction, he developed an intense rage and said that even though the medical board ridiculed her for placing his asthma on an emotional basis, she should be willing to risk her reputation as a physician to save his life. The therapist's acceptance of his rage as belonging to his conflict, coupled with this frustration of his dependence on her, constituted the first and most basic step in the resolution of his conflict and the relief of his asthma.

After this, the patient felt more independent. He began dating girls and even had the courage to ask for another date when refused the first time. After dating one attractive girl for some time, however, he became concerned over the fact that she still entertained some affection for a former beau, and so he broke off with her. His insistence that the therapist give her opinion about this provoked from her the comment that perhaps what he really wished was to find out something about the therapist's personal life and attitudes. The patient was surprised but admitted the charge.

For several interviews thereafter, he expressed anger over the ' faithfulness of married women '. Finally the therapist suggested that he was more in conflict about those who were faithful to their husbands. His rejoinder that he could not have any conflict about the therapist as she was ' too old ' for him, was met with the comment that possibly he feared he was ' too young '. The patient was breathing heavily and expressed amazement that he could think of nothing to say. Only rarely, he said, did he feel so uneasy in talking to ' men or women '. Asked, ' Why bring men into it ? ' he retorted resentfully, ' Why not ? ' At this point, when he was breathing with difficulty and seemed on the verge of an attack, the therapist observed quietly that possibly his concern had something to do with her husband. The patient appeared startled, but relaxed almost immediately, his noisy breathing subsided, and he admitted he had been wondering about him.

Just after this, the therapist went on her vacation. An interview shortly after her return may be regarded as the second decisive step in the treatment.

When the patient came to the office, he was in the midst of a severe asthma attack which had not responded to ephedrine, and was obviously suffering great distress. He said that he had had several attacks during the week, but always at night. This attack he again explained on the basis of having had to hurry. After a few minutes, he said he could remember nothing they had discussed before her vacation. It occurred to the therapist that he was probably angry with her for going away with her husband, so she mentioned that when he had found his girl was still somewhat attached to a former suitor, he had dropped her immediately. The patient understood the allusion. 'Oh, yes,' he said, 'and this probably brings up your husband whom we were discussing as a rival before you left.' Suddenly the asthma stopped completely. The patient began to laugh and said he could hardly believe it, that not even adrenalin had ever ended an attack so suddenly. He was at last convinced that he had been inhibiting feelings toward the therapist and he now confessed erotic impulses to her.

In the following interviews, the patient expressed resentment and humiliation as if he had been a rejected suitor, and he depreciated the therapist. Within a few weeks, the asthma had subsided entirely and the patient, for the first time, began to want to share things with women on an equal plane. Having found that rejecting the analyst and depreciating her as a woman was accepted calmly, the patient said he no longer felt anxiety about telling a girl he did not love her, he no longer feared that such a rejection would precipitate a rage in the girl that he would not be able to endure. He now felt a great sense of freedom and could act with both friendliness and masculine agressiveness.

As a result of the improvement, not only in removal of the symptom but in general change of attitude, the therapy was terminated in the ninth month.

The patient has now been an officer in the medical corps for three years and is feeling very well. He has had only one slight attack of asthma, a few months after he entered the

service when he was in a difficult situation. When heard from last, he was engaged to be married.

Essential Hypertension—The true cause of this very widespread disability of middle life still escapes us. It would seem to be due to the innate or induced failure of the moderator mechanisms which normally regulate variations in blood pressure consequent on different necessary adjustments to events in the body or its environment. Constitutional factors, neurogenic strains and humoral alterations have all been blamed without any convincing evidence in favour of any of them. The importance of renal function and renal disease as links in the chain of the development of hypertension has been well recognized but inadequately explained. The increased tempo of life and emotional strain have been cited as causative factors and many accounts have been given of apparent cure of hypertension by psychotherapy.

A case described by Alexander [1] is illustrative of the sort of results which may be achieved.

The day by day B.P. fluctuations of a forty-seven-year-old male suffering from a chronic depression, chronic alcoholism, and essential hypertension were compared with the daily psychoanalytic material. A definite correlation was found between emotional tensions and fluctuations of the B.P. The nature of the emotional tensions was identified as inhibited, but not deeply repressed aggressive impulses directed, partly inward against the patient's own person in the form of depressions, partly turned outwards in the form of hostile feelings. It was observed that during a period in which the patient was in an exceptionally calm state his B.P. was definitely lower and showed considerably smaller fluctuations. Towards the end of psychoanalytic treatment there was a slow downward tendency of the average B.P. level.

A case of essential hypertension with a B.P. fluctuating between (systolic) 200 and 140 and (diastolic) 130 and 80 in a male of forty-one was analysed.[2] He also suffered from seminal pollutions, ejaculatio praecox, anxiety, a cardiac neurosis accompanied with precordial distress, tachycardia and extrasystoles. The analysis showed a masochistic

[1] Alexander, F. 1939. *Psychosom. Med.*, i., p. 139.

[2] Schwartz, L. A. 1940. *Psychosom. Med.*, ii., p. 409.

submissive attitude toward a dominating mother, leading to a masochistic submissive attitude to a rigid superego and a deep homosexual attachment to the parent of the same sex. Further, there developed a chronic unsuccessful unsatisfied rebellion and hostility in protest against this submission. The rebellion and hostility were conscious or near to consciousness but yet not expressed directly because of fear of loss of love. The masochistic homosexual submissiveness was not conscious and bitter hostility opposed making it conscious in the analysis.

The analysis was terminated after the patient had remained symptom free and well for over two months. The evidence in this case suggests that the patient's hypertension may be connected with long continued repressed hostility and rage with the consequent production of constant conflict which the individual can neither escape or solve. Once the conflict was solved the hypertension which was only a symptom disappeared. This accentuates the principle that we must treat not only the disease but also treat the patient.

It would seem that to be effective in hypertensive conditions psychotherapy must take the form of fairly deep analysis. Merely telling the patient not to worry is, needless to say, useless, and unless the emotional tension can be permanently relieved there will be no lasting effect on the blood pressure.

Katz and Leiter[1] consider that the regulation of blood pressure depends on the moderator mechanisms situated at the base of the aorta and carotid. These may be influenced by many factors, constitutional, humeral, but they believe that emotional strains may have a definite influence, especially in view of the fact that there is some, but not yet conclusive, evidence to show that blood pressure tends to be higher in those subjected to the modern tempo of living. They think, moreover, that mental energy may represent a special manifestation of energy released by stimulation in the sense organ periphery and that this, which is imperfectly understood, may be able *per se* to initiate nerve impulses to control blood pressure.

To sum up, it would appear that the avoidance of unnecessary emotional, as well as physical strain, in early and middle

[1] Katz, L. N. and Leiter, L. 1939. *Psychosom. Med.*, i., p. 101.

life may do much to prevent the onset of essential hypertension, even in those constitutionally disposed, and if the condition can be recognized early, it may be possible to reverse the process, provided that the emotional strain is permanently removed, either by a drastic change in the environment, or by deep analysis or better still, by a combination of both.

Peptic Ulcer—The actual treatment of peptic ulcer by the psychotherapist is not described to any extent in the literature probably because, although believing in the important contribution of emotional stress in the genesis of ulcers, few have the courage to believe that psychotherapy alone should be used in the treatment of a condition which may end fatally by haematemesis or perforation. The following case is quoted from Alexander and French.[1]

A middle-aged lawyer came to the psychiatrist for a differential diagnosis of symptoms indicating peptic ulcer. He remained on treatment for a total of twenty interviews over a year's time with excellent therapeutic results. He suffered from symptoms which had been diagnosed by x-ray two years previously as peptic ulcer. Since then his symptoms had become increasingly severe in spite of careful diet. Now his doctors advised surgery. He had decided, however, to find out whether emotional factors were responsible for his suffering before he submitted to the operation. Although his underlying idea must have been that an operation would not be necessary if emotional factors were responsible for the ulcer, he approached the therapist (female) with the greatest reserve, emphasizing repeatedly that he did not want psychotherapy, did not want to be psychoanalyzed.

The patient's very articulateness about his problems made it obvious that he could be approached only on his own terms ; the therapist suggested that he might prefer to talk with a male therapist. The patient refused, however, and continued the consultation with even greater eagerness—also with greater intellectual defensiveness.

Almost immediately it became obvious to the therapist that the patient did not want to go to a male therapist because of a strong competitive attitude toward men.

[1] Alexander, F., and French, T. M. 1946. *Psychoanalytic Therapy.*, p. 17. New York.

The therapist did not know whether an operation would be necessary or not but, understanding the patient's immediate need and realizing that he was highly sensitive to rejection (he had already told her of several severe setbacks in his professional life), she agreed to make a ' differential diagnosis ' and arranged another appointment for him for the next day. Although the patient had said he did not want psychotherapy, it was obvious that he was eager to return.

During the next two consultations the patient recounted his past history and discussed his present conflicts. He had been the youngest child in a large family and had received more attention from his mother than had the other children. All the children idealized the mother but were in open rebellion against their ill-tempered father. The patient's ambition had been to live up to the ethical demands of his mother, who died during his adolescence. He developed strong intellectual and social ambitions, he was given to severe self-criticism, he became a ' compulsive neurotic character ' constantly fighting all tendencies in himself which he thought inferior.

His sexual development had been slow but normal. When he was about twenty-six years old, he had married the girl he loved, in many ways what the patient himself wanted to be—an outgoing personality, a social and professional success. They had had a satisfactory marital life for more than twenty years.

In the last few years, the patient had suffered from what he called ' emotional hypersensitivity '. He was upset by a decline in his business, the result of general economic changes and not due to any failure on his part. Although he freely admitted his worries and his irritability, he could not admit that he had ever envied another person success. While he withdrew in many ways from competition, he became quarrelsome and exaggeratedly self-assertive. He blamed his moodiness on his business situation and was unaware that much of his emotional tension was caused by the success of his wife. Nor did he permit himself to recognize that he felt forced into competition with the men whom his wife met in her professional career.

When these attitudes were pointed out to him, the patient responded with keen insight. He admitted with genuine

surprise that he could sense the reaction in his stomach ; he suddenly realized that when the names of certain of these men were mentioned he could actually feel his gastric juice flow. With this realization—although the therapist did not call this fact to the patient's attention at the time—the differential diagnosis demanded by the patient was achieved.

At the beginning of the fourth session, the therapist encouraged the patient to let his present problems rest while they tried to find out from his past experiences why he responded to his present problems in this particular way. During this interview the patient recalled several experiences of his childhood and (in short flashes) saw various neurotic aspects of his personality. He recalled his fear of boys toward whom he had felt inferior, and his effort to overcompensate for his timidity by hostile and daring acts. He recognized the feeling of guilt arising from his hostility and came to understand that his aggressive tendencies were responsible for his hypersensitive superego. Although this newly gained insight was far from being integrated into his personality, it permitted him to see that his emotions might be responsible for his present worry, for his character disturbance as well as for his physical distress.

Following this session, the patient decided to throw away all his diet regulations. As he left this interview, the patient said to the therapist, ' I won't worry any more. I'm your worry now '. This statement was the first and only admission of any emotional dependence on the therapist. This expression of the patient's dependent needs was not interpreted at the time, nor was it referred to during the whole course of the treatment. The omission of interpretation meant, ' You may relax and feel dependent,' and it was thus the patient took it.

Two days later, in the sixth session, the patient told the therapist that he now felt completely relaxed ; he had discarded all his medicine, had given up his diet, and was without distress. Although the therapist could not be certain that the patient would not overtax his stomach, she indicated no concern. The rest of the session was taken up by discussion of problems within his office and of his dependence on his partners. While he was able to recognize how the protected

emotional situation of the office kept him from making new ventures, he also realized that he often behaved aggressively and was over-critical of the others in an attempt to compensate for his hidden dependence.

At this point, after six sessions, one could say that the immediate goal of the therapy had been achieved. The patient was convinced that emotional factors were causing his stomach symptoms ; and the symptoms, temporarily at least, had disappeared. It must be noted, however, that this success was made possible only because his dependence had been satisfied by his relationship to the therapist.

Although his emotional tension was probably caused, fundamentally by the conflict between his dependent needs and his competitive strivings, this tension was constantly aggravated by his fear of losing his wife and by the competition with the men whom his wife met professionally and the consequent hostility he felt against them. He felt that he should ' be above ' such emotions as jealousy and he was afraid to do or say anything which would disturb the *status quo*. Because the therapist felt there was a better chance for a lasting therapeutic result if the patient could admit those feelings and discharge some of his hostility, she decided to continue the therapy for a while longer.

While the first six sessions took place in two and a half weeks, the following fourteen sessions were spread out over a year, chiefly because the patient was often out of town.

This was the stormier part of the treatment. During this time his confidence in the therapist often had to outweigh his anger and fear that the therapeutic procedure might endanger his marriage by making him realize his resentment and hostility toward his wife.

After the twentieth session, the patient felt that he did not ' have much to say any more ' ; that he was now able to handle his marital problem. He knew from experience now that when his emotional tension in this sphere diminished, his ulcer symptoms also disappeared.

Two months later the patient came for three more consultations. His progress had continued and he was now firmly convinced that his gastric distress had been due to emotional, not organic, difficulties. He had become able to

admit to himself his competitiveness and hostility, and so had had little or no distress. Another follow-up interview two years later showed that the patient was still well and almost entirely free from the ulcer symptoms.

To quote Van der Helde,[1] ' It is not maintained that every ulcer patient needs a psychoanalysis, but rather that those cases in which the psychogenic factor appears to be important require an expert psychotherapeutic handling just like any other psychoneuroses.'

These examples illustrate how the psychotherapist can help in the treatment of selected cases of true psychosomatic disease. It is obvious that it is neither possible nor desirable to subject every patient suffering from these diseases to the time consuming discipline of psychotherapy, especially as at present this apparently must take the form of deep analysis, and a good deal of research is needed to determine which cases should be referred for this treatment. Such research however, is the growing point of practical therapeutics and in our own generation we have observed the clarifying results of pure research in the fields of endocrinology and radiology, and so we may look forward with confidence to the time when a similar clarity will be achieved in the field of psychosomatic medicine.

[1] Van der Helde, C. 1940. *Psychosom. Med.*, ii., p. 409.

CHAPTER V

THE VISCERAL NEUROSIS

A LARGE part of a physician's time is taken up with the diagnosis and treatment of functional disease, that is, disease not directly dependent on any gross structural change in the organs from which the symptoms arise. These symptoms are due to altered functional activity of the muscular or secretory elements of the various systems of the body, and this altered activity is generally a response to emotional states mediated through the autonomic nervous system. These conditions are therefore closely related to and merge into the psychosomatic conditions.

Though we can say that the efferent channels lie in the autonomic system and that this system has close connections with the hypothalmic nuclei well known to be closely connected in turn with the centres of emotional expression, we know little or nothing specifically of the seat of the emotions themselves. It is better at present that we should avoid attempts to translate human emotion into terms of exact anatomy and physiology and should be content to limit ourselves to ideological hypotheses which seem to fit the facts and which offer lines for successful treatment.

We have at least two major factors to discuss in the genesis of the visceral neuroses, the emotional background and the channels of its expression. With regard to the latter, it used to be thought that people could be divided into two groups, the sympatheticotonic and the vagotonic and that each group would always show the appropriate visceral activity in response to emotional change—the vagotonic tending to conditions such as spastic colon and asthma and the sympatheticotonic to cardiac overaction and hypertension.

Though at the two extremes such a division is possible, it serves little useful purpose, as most people are capable of

displaying both types of response at different times and in differing circumstances. In either case, however, recognizable syndromes do result from autonomic imbalance, the symptomatology depending on which organ or tissue bears the brunt of the altered activity. In some cases more than one organ may be affected as when a patient suffers from Da Costa's (effort) syndrome and a spastic colon or from a gastric neurosis and asthma. Skin reactions of various patterns—eczema, erythema, etc., commonly seen in association with the visceral neuroses, owe their origin to the same cause. These skin reactions cannot be discussed here in detail but are nevertheless of great importance. Pruritis ani and vulvae in particular are commonly of psychoneurotic origin and require both local treatment and treatment directed to the emotional background. It might be supposed that such conditions would be readily responsive to psychotherapy alone, but in fact, except in a few cases responsive to deep and prolonged analysis, we find that this is not the case, and the cynical critic may well ask whether, when analysis is very prolonged, spontaneous recovery would not have taken place in any case. Psychotherapy is chiefly concerned with explaining the genesis of the symptoms to the patient, and so enabling him to avoid as far as possible the factors which are responsible for his illness. The patient is usually freed from a load of anxiety when he realizes that his symptoms are not due to some deep seated organic disease, and is thus better able to face difficulties in his life situation.

As the underlying factors of causation and treatment are common to all the visceral neuroses they will be considered together. It is interesting to speculate why in one person the stomach, in another the colon and in a third the cardiovascular, respiratory system or skin should bear the brunt of autonomic imbalance. In some cases there is a hereditary factor at work and the same type of sensitivity is seen through the generations. This inherited factor prepares the ground for responses such as asthma and urticaria so that the addition of emotional factors or the presence of an appropriate allergen may be sufficient to provoke an attack. This was brought out by Adler in his theory of organ inferiority.

Familial incidence may however owe its origin not to a hereditary factor but to suggestion. Thus one man may owe his effort syndrome in part to the fact that his father died of coronary thrombosis, while another suffers from dyspepsia because his mother had a gastric carcinoma. Cardiac neurosis is often induced by an erroneous diagnosis of heart disease in childhood or by the patient's own misinterpretation of normal cardiac sensations. In other cases the presence of an underlying organic lesion forms the basis for a visceral neurosis in the affected organ, and the symptoms of the nervous disturbance, engrafted on to those of the organic disease make an accurate assessment of the case very difficult—this is particularly noticeable in the case of effort syndrome following a coronary thrombosis ; there is no doubt that many of these patients suffer from symptoms which are entirely due to anxiety and that much unnecessary invalidism is thereby caused.

In some cases the circumstances in which the emotional disturbance arises determines the visceral response. Thus a child who on one occasion wets the bed as a result of fear or a distended bladder may discover that he has thereby produced the attention to himself which was previously lacking ; the discomfort of a wet bed is a small price to pay for the focussing of parental attention on himself, and he is unlikely to give up such a source of emotional satisfaction so long as it serves his purpose and as long as without it he is starved of the affection and attention which he rightly considers his due. Constipation in children is not uncommonly made to serve the same purpose but it is better classed as a manifestation of negativism than a true visceral neurosis.

In a few cases the mechanism of the conditioned reflex is at work. The patient who has once had a severe gastric upset after taking a particular food is liable to suffer from a gastric upset on taking the same sort of food afterwards even though his original illness was due in the first place to some additional factor operating at the time and not the food itself. A patient who has become nauseated and vomits after taking sulphanilamide tablets may easily become inclined to be sick after taking any tablet or pill. Though such cases might be considered to be in a different class from the ordinary visceral

neuroses, they are in fact not so, because in almost all of them there is an underlying tendency to a psychoneurotic reaction without which the condition could not have become established. This class of case is of some importance because occasionally a patient who is living on an inadequate diet has gradually come to this state by successively eliminating from his menu one sort of food after another in the erroneous belief that they are the cause of his symptoms. These cases must of course be differentiated from cases of true food allergy with which they probably have nothing in common.

Apart from the consideration of the immediate causes of visceral neuroses the psychoneurotic background is all important, its recognition is an essential in the diagnosis, and its proper understanding is a prerequisite of successful treatment.

Unfortunately it must be admitted at the outset that one of the factors in many cases of visceral neuroses is constitutional and this cuts the ground from under the psychotherapist's feet; inherent temperamental instability has already been discussed; it has to be considered as a possible factor in every case and when it is prominent little more than the alleviation of symptoms can be hoped for. These patients are a burden to themselves and others, but if they are fortunate enough to make a suitable marriage with a dominating but affectionate partner, or find an attractive backwater in life they may find happiness in a dependent and rather 'coddled' state of existence.

Other factors are, however, more amenable to treatment. Anxiety both reactive and psychoneurotic shows itself very readily by visceral disturbance. As a temporary inconvenience this visceral response is known to everyone, but the threshold for its appearance varies in individuals and probably depends on the two factors of inherent instability and on a basic insecurity dating from childhood. With the exception possibly of asthma, all the vegetative components of emotional expression have their counterpart in normal physiology and may be regarded as biological reactions which at one time served some useful purpose as accompaniments or adjuvants to fight or flight. They are responses in the face of real or imagined danger and may therefore be regarded as positive or

negative reactions of aggression. Under civilized conditions anxiety is more likely to be operative than fear, though in war-time fear may play the more important part.

The conception of psychoneurotic anxiety as a natural outcome of repressed aggressiveness resulting from fundamental insecurity is a very useful one. In civilized society actual fight or flight is often quite impossible, because the threat is too intangible or is not realized in consciousness or is repressed from it, or because society no longer countenances the forcible removal of the hostile persons. Given a situation therefore in which fight or flight would have been the natural primitive reaction, the visceral disturbance will occur as an isolated phenomenon without any related purposeful bodily activity; or at all events without anything more than a certain amount of motor restlessness. Failure to deal adequately with the situation for any of these reasons leads to persistence of symptoms, and as these are not ascribed to their true cause they may themselves become the cause of further anxiety. The condition then leaves the realms of physiology and becomes psychopathological. Thus the man with dyspepsia may not recognize that he is 'sick' of his business worries or of his wife, and the woman with the spastic colon may be suffering not as she thinks from the effects of a band of adhesions in her abdomen but from a band of gold on her finger.

Some cases are on the borderland of physiology and pathology as the following case illustrates.

A well-balanced man with no discoverable neurotic tendencies had occasion to be in London during most of the bombing. He did not suffer from any conscious fear and indeed did not make use of the shelters provided. He suffered from some undue frequency of bowel action and had pain along the course of the colon. He was treated by colonic lavage and was repeatedly x-rayed to relieve his anxiety about the possibility of new-growth. The pathologist had found excess of mucus in the stools and this was not surprising. It was with difficulty that the patient could be persuaded that the colonic disturbance was related to the bombing, but that such was the case was indicated by the fact that it disappeared after leaving London and reappeared during the bombing of his home town. In this case there was no conscious emotion whatever to

rovide for the patient a necessary link between his symptoms nd their cause.

Diagnosis : The finding of organic disease in a patient was ntil recently tantamount to giving him a ' certificate of ıerit ' which at once removed him from the despised class of eurotics. It is now realized that true organic disease may we its origin to mental illness, as is seen for example in hyper-ıyroidism, peptic ulceration and possibly in arteriosclerosis. Ioreover mental factors may lower the patient's resistance ɔ infection or be an indirect cause to the deficiency diseases y causing diminished food intake. Even accidental injury ıay result from the inattention which a preoccupied mind ıduces ; and in this connection it has been an interesting tudy to investigate the mental background of people involved ı road accidents or in accidents at work. Dunbar definitely ɔcognizes accident-proneness, tendency to abortion and imilar conditions as psychosomatic.[1]

Conversely organic disease has its repercussions in the atient's mind, and organic disease in a viscus may, as has een indicated earlier, determine the localization of neurotic ymptoms. It is obvious therefore that both aspects of the lness must be considered before a proper appreciation of the atient can be made.

Apart from this group of mixed etiology, there still remains large group of cases for which no organic basis can be found. 'he diagnosis of this group was formerly made by a process f elimination—if no organic disease was found the condition 'as said to be functional, and the result was that mistakes in iagnosis were frequently made. It is now realized that ositive evidence of psychological illness should be sought for, oth in the history and in the examination of the patient, efore a diagnosis of psychoneurosis is made. In order to mphasize the necessity of both careful examination and a ıll history, one need only mention those cases in which a atient fearing that she is suffering from some malignant isease, such as cancer of the breast, disguises her all too ıstified fears by giving an account of vague symptoms ɛlated to other parts of the body in such a way that the octor might well be led into making a diagnosis of psycho-

[1] Dunbar, F. 1946. *Psychosomatic Diagnosis.* New York.

neurosis if he failed in his obvious duty to make a full physical examination. It is not easy to understand why a patient with a fungating mass in the breast or a blood-stained vaginal discharge should say nothing about it when she goes to see her doctor; nevertheless, she may complain only of headaches and tiredness in the hope, possibly, that if the doctor does not find anything wrong she can console herself that her fears are groundless. This ostrich-like behaviour is not uncommon in women and leads to not a few errors in diagnosis. It is found sometimes also in men who have good reason to fear that they have acquired venereal infection.

The way the history is given with the abundant use of superlatives, the multiplicity of complaints, and the past history of many illnesses, examinations and explorations all point to a psychoneurotic preoccupation with bodily health. The circumstances in which the illness has arisen may be of the utmost importance in diagnosis and a knowledge of the patient's environment, particularly his home life, may be necessary before the etiology is understood. The history will usually disclose difficulties of adaptation in the past, often dating from childhood and it will be found that these difficulties have been associated with some visceral disturbance that has determined the particular type of neurosis.

The symptomatology is of great help in the case of cardiac neurosis but of less value in the alimentary and respiratory systems. In cardiac neurosis the symptoms run very true to type and are almost diagnostic. Palpitation, left mammary pain, breathlessness associated with a feeling of suffocation, and dizziness form a group of symptoms which are almost uniform in every case. On examination the heart is found to be normal except for a tendency to tachycardia. Systolic murmurs of only physiological significance are sometimes heard and it is often this finding which has led some medical attendant in the past to sow the seeds of the neurosis by directing the patient's attention to it.

In spasmodic asthma the history will only be of help in deciding how far allergy and how far psychological factors are responsible for the patient's condition. Even where allergy is known to be an important factor, psychotherapeutic help is often of great value in diminishing the frequency of the

attacks, since one attack may easily suggest another ; as in many other neurotic illnesses treatment of the relatives is often more important than treatment of the patient.

In the case of gastric neurosis so little is known of the etiology of peptic ulcer beyond the fact that it occurs in patients of a particular habitus, and that anxiety states predispose to it, that it is at present almost impossible to divide the neurotic cases from the so-called organic, and it may well be that given some added factor, peptic ulceration is a part of the natural history of gastric neurosis. A similar difficulty is found in attempts to diagnose the colonic neuroses. Both mucous colic and spastic colon may be of neurotic origin or be the sequelae of a true colitis of infective type.

'The sorrow that has no vent in tears may make other organs weep.' This is certainly very true of the stomach and colon and might well head a chapter on disease of the skin also. Haematemesis and ulcerative colitis follow so commonly on nervous upsets that it is impossible to avoid the conclusion that there is an etiological association. Experimental work on dogs has shown that acute gastric erosions with bleeding can be produced by lesions of the pituitary body, and it seems likely that hypothalamic disturbances in men has a like effect.

There is one very important question which has a direct bearing on the value of psychotherapy in these cases, and it is a question to which there is as yet no final answer. Is the alimentary disturbance the result of a neurosis, or are the neurosis and the alimentary disturbances both the result of constitutional factors which at present we are unable to assess. It would seem possible that a particular endocrine balance of constitutional origin might well be the primary factor in these cases, and this is supported by the fact that alimentary neurosis tends to occur in people of a particular type and build. It is probable that we should be as willing to accept a constitutional cause for emotional excitability with its attendant visceral manifestations as we are to accept a constitutional basis for the volatile Latin temperament and the phlegm of the Anglo-Saxon.

If this is so, it follows that psychotherapy should be directed more towards adjusting the patient's life situation and his attitude to it, than to any deep analysis designed to alter

personality. In other words we cannot hope to turn a race-horse into a quiet cob. Fortunately in many cases psychological conflict is the chief link in the chain of causation and the resolution of this may be sufficient to relieve the patient of his symptoms.

In the treatment of visceral neurosis in the adult, the reassurance that comes after careful clinical examination may go a long way toward curing the patient, but as a rule more is required. Psychoneurotic anxiety will require some degree of analytical treatment, the depth of such analysis depending on the nature of the conflict which is present. Where organic disease is present as a basis for neurosis it must be faced and the patient must be helped to take an objective view of his limitations. Intelligence in the patient is a *sine qua non* and fortunately such patients usually have an intelligence above the average.

The treatment is complicated in many cases by the fact that the illness has become a prop to the patient's existence—it has become a conversion symptom which serves all the purposes of the hysterical reaction whether to enable him to avoid disagreeable duties, to escape from difficult situations, or to achieve a much desired sympathy and protection. Hubble has given an account of Darwin's visceral neurosis and shown how it helped to avoid distractions and enabled him to concentrate on his scientific work. More often, however, it is used as an excuse for selfishness or domestic tyranny. The psychotherapist has the difficult job of making the patient see the use to which he is putting his symptoms and of endeavouring with the latter's co-operation to discover their origin. The final synthesis of the patient's personality into something better able to tackle life's difficulties is the ideal to aim at. Ultimate success will depend on the inherent stability or instability of the patient, his intelligence and willingness to co-operate and finally on the extent to which the underlying conflict can be eradicated.

Lastly the difficult question of the vesical neuroses must be discussed. In its simplest form it is known to most of us as a tendency to frequency in times of fear or anxiety. What is not commonly known is that definite polyuria is often associated with this frequency and sufficient attention has not been

given to this factor in the management of that most complex neurosis manifested by nocturnal eneuresis. If this fact were properly appreciated we should not find so much attention paid to trifling anatomical variations in the external genitalia or to minor pathological findings such as thread worms and the like. It is possible of course, that a severe grade of phimosis or balanitis may occasionally be the cause of this condition, but the multiplicity of surgical treatments bears witness to the ease with which we fall into the mistake of ascribing etiological importance to slight divergencies from a so-called normal physical state. The genesis of this condition varies, but where it is persistent there is practically always a psychological factor at work. In the first place it may be due to faulty training—the child is not given a chance to empty its bladder last thing at night, and although occasionally a tight foreskin may be sufficient to prevent him from doing so, after infancy this is a very exceptional cause. Normally a child develops control quite early and naturally, except for very occasional accidents. If however he feels a sense of insecurity, two factors come into play: first the natural visceral response to fear will cause the bladder to be emptied during frightening dreams in exactly the same way as a fright during the day will cause at least the desire to evacuate the organ, and secondly the attention which must necessarily be directed to the habitual bed wetter will place him in the forefront of parental attention, a position he feels he has a right to occupy. It is for this reason that nocturnal eneuresis so frequently begins after the birth of a younger child. To avoid this and other nervous disturbances it is absolutely essential that each child in the family should feel, not that its parents' attention is being divided, even equally, but that each is the object of a complete and all embracing love, a love moreover which is not fundamentally affected one way or another by his good or bad behaviour. This is one of the most important points in the whole of psychological medicine. There is not the slightest doubt that the stability or otherwise of the adult personality is dependent on the stability of the parent-child relationship in the early days.

When nocturnal eneuresis has become established it takes on the nature of a time conditioned reflex so that not only

must the psychological factors be adjusted but the reflex must be inhibited. To this end sedatives are helpful and the child must be lifted regularly before the time at which he usually wets the bed. During the war the evacuation of children from the cities brought nocturnal eneuresis to the status of a national problem. In many cases it was found that the child was a habitual bed wetter—that in fact the condition was purely a bad habit due to lack of training and such cases responded well to careful attention by the foster parents ; in other cases the condition was a fear reaction due to separation from home or due to unsatisfactory treatment by the child's temporary guardians ; many of these children were eventually returned to their parents, or other more suitable homes found for them ; in the latter case it was striking how quickly the nocturnal eneuresis would disappear. Positive suggestion, regular emptying of the bladder and encouragement of each advance toward normal control are the important lines of treatment, but above all, attention must be paid to the provision of a secure emotional background for the child. Analytical treatment is not usually called for except when the eneuresis is definitely associated with nightmares, when the resolution of the underlying fear and insecurity may be most effective.

CHAPTER VI

THE RELATION OF RHEUMATISM TO MENTAL ILLNESS

CARDIAC neurosis always raises the question of rheumatic infection, and rheumatism has a special interest to the psychotherapist because of its association with chorea and because there is evidence that psychological factors may lie at the root of many of the so-called growing pains of childhood. Occurring as it does during the impressionable years, the mismanagement of rheumatic infection particularly as regards cardiac disease, may sow the seeds of psychoneurosis in later life.

Hubble [1] has given an excellent review and reassessment of the various causative factors in the production of the rheumatic state. He points out that in the etiology of both chorea and growing pains there is an underlying instability with a tendency to shyness and labile emotionalism which is present from early years.

If this stage is not properly managed by sedation and adjustment of environmental difficulties, the emotional tension may be externalized as tiredness and pain in the limbs; similarly prolonged emotional strain such as is felt by a child who is being urged toward scholastic distinction, or the addition of psychic trauma such as sudden fright, may precipitate an attack of chorea.

At what point the infective element of rheumatism comes into the picture is not yet settled. Rheumatism may precede or follow chorea but many cases of chorea are never at any time complicated by 'rheumatism' as it is generally described.

It may be that given the right soil, as manifested by years of excitability and emotional instability the rheumatic poison can induce chorea by causing the same change in the central

[1] Hubble, D. 1943. *Brit. Med. Journ.*, i., pp. 121, 154.

nervous system as is caused by psychic trauma. Moreover as we see in other conditions there is a reciprocal relation between bodily disease and psychological symptoms and it is probable that mental factors render the body more liable to rheumatic infection.

The importance of all this to the psychotherapist, using the term in the wide sense to include the physician with a psychological outlook, is that he has an important part to play in the prophylaxis and treatment of these conditions. If the child is seen at the stage when his symptoms are limited to excitability or limb pains with no evidence of carditis or arthritis, treatment should consist in sedation, preferably with small doses of phenobarbitone and an investigation of the child's family life and school environment so as to secure his smooth adjustment to them. Often these children, being unusually intelligent, are pressed forward at school with a view to obtaining scholarships and distinctions. They carry home large quantities of homework which keeps them occupied in the evening and induces restlessness and sleeplessness at nights, predisposing them to an anxiety state. Holidays in the country are the ideal treatment for such children provided that their anxiety and that of their parents is not too deep-seated to be left behind, and in the absence of signs of active rheumatism no restriction whatever should be imposed. In some cases, however, psychotherapy may be necessary before or during the holiday, and it must be remembered that town children may take some time to adjust to country life. In these cases the experience of the specialist may be useful in confirming the diagnosis, but the actual treatment can well be left to the family doctor.

Much work has been done on the relationship of psychological causes to what are loosely called rheumatic pains. The cases can be divided into three groups, hysterical, fibrositic or otherwise organic, and the large group in which there is a hysterical factor superimposed on an organic basis.

In the first group are all those cases of pain in the lumbar or cervical region which follow some trivial injury or arise *de novo* as a form of conversion hysteria. Such cases were commonly seen during the war, and in civilian life they form not a small proportion of the claims for compensation after

car and other accidents. Careful examination fails to show any evidence of organic disease and the pain and tenderness do not conform to any anatomical basis, nor do they have any constancy of position or severity. Frequently light tapping on the spinous processes provokes complaint of pain shooting down the legs, and the suggestibility is such that the pain can be made to radiate from such bony points as the crest of the ilium in almost any suggested direction. Such cases respond quickly to psychological treatment by which the underlying conflict is resolved and the 'need' for the symptom is removed.

With regard to the second group, this does not concern us except to emphasize the necessity of most thorough and careful examination of the spine or other area which is the seat of pain. In this connection it is well to utter a word of warning about the significance to be attached to lipping of the lumbar vertebrae. This is such a normal finding in middle age that it should not *per se* be regarded as a sufficient cause of symptoms, although it probably does indicate some chronic strain. Too often however, the patient has been told that he has an arthritis of the spine. In some cases this may lead to undue alarm, but in others to a smug satisfaction and a feeling that he is thereby excused for undertaking his duties in life.

The third group in which there is a psychoneurotic factor in addition to an organic lesion, is the most difficult to deal with. Each case must be assessed on its merits after a review of the situation as a whole and successful therapy will depend on appropriate attention to both factors. The patient's attitude to his illness cannot be taken as a guide in all cases as only too often these unfortunates have been subjected to so much opposing council, bullying, cajoling, and pooh-poohing or alternatively, to lavish and suggestive treatment, that there is no wonder that they take a guarded attitude toward any attempt at reassessment of their condition. Every effort should be made to adjust outstanding psychological difficulties such as those concerned with compensation or capacity to undertake work in the future or other causes of anxiety and appropriate treatment should be given to local disease where it is found.

Backache in women is a common complaint and its etiological explanation has passed through various phases according to the changing fashion in pelvic pathology, notwithstanding the fact that *gross* disease of the pelvic organs is seldom associated with lumbar pain. Up to a point this symptom should be assessed on the same lines as in men except that the lordosis of women makes posture and strain more common causative factors, particularly in middle age when increase in weight may cause more load on the ligaments of this part of the back. In certain cases there is no doubt that very real backache accompanies the vascular changes of the menstrual cycle, and this may well be due to the influence of autonomic afferent impulses on the corresponding somatic segments in the spinal cord.

Coccydynia is a neuralgia and not an arthritis and in most cases entirely psychic in origin. The less local treatment given the better. It occurs chiefly in women and is ascribed to various causes such as childbirth, falls and other traumata. That the condition is determined at a relatively high level of the nervous system can readily be shown by the demonstration that although light touch on the coccyx causes exquisite pain, this terminal portion of the spine can be pressed upon and even moved freely in the course of a vaginal examination. Psychological treatment of the underlying anxiety should follow a careful examination and reassurance as to the absence of gross disease. In no circumstances should surgical operations or injection of the nerves with alcohol be carried out. Such procedures are foredoomed to failure, and only convince the patients that he has some serious local disease.

CHAPTER VII

THE ENDOCRINE BACKGROUND

ENDOCRINE dysfunction is not uncommonly a factor in the etiology of psychoneurotic illness and occasionally as in some cases of thyroid disease and at the menopause the disturbance in this system may precipitate a true psychosis.

It is therefore important that the possibility of such a factor should be borne in mind, particularly as modern therapeutics offer a hope of successful treatment in many cases.

It would seem that the endocrine system normally gives smoothness and prolongation of action to the more transient responses of the autonomic system to environmental changes. It thus acts not only as an effector mechanism, but also serving the function of a flywheel to the nervous system. Though we are lacking in knowledge of the psycho-physiological processes involved in this relationship and though we know little of the way in which various secretions act together to allow of normal mental function, there are a number of pathological mental states in which we can say with certainty that the endocrine system is at fault and that abnormal action of a particular gland is responsible for most of the clinical picture as we see it. Even in these cases however it is necessary to remember the interplay not only between one gland and another, but also the mutual interaction of the glands and the central nervous system, and through the latter with the emotional state of the patient.

The abnormal functioning of the endocrine team produces both disturbances of bodily structure and personality changes and it is for these latter that help may be sought from the psychotherapist. Great disappointment and waste of time may result if the latter does not recognize the true state of affairs. In the fully developed clinical picture it is unlikely that the endocrine factor will be missed, but in others the

personality change may overshadow the physical abnormality and mistakes are liable to occur. On the other hand emotional trauma may so upset the endocrine system that the neurotic factor is overshadowed by the physical effects of endocrine pathology and the psychogenesis of the illness may be obscured ; anorexia nervosa is an example of such a condition.

In this chapter, for convenience, a somewhat arbitrary allocation of clinical pictures to particular glands has been made, and it will be realized that in many cases our knowledge does not justify such a close assignment. Some sexual disturbances are for example described as of gonadal origin though they are probably related as much to pituitary and adrenal disease, and similarly hyperthyroidism and its personality disturbances may have their origin primarily in pituitary dysfunction.

The Pituitary Gland.

The syndromes associated with disease of this gland often include some mental disturbance. This may be the direct result of the disease or a psychological reaction to the resulting changes in bodily structure and configuration. The direct results are few in number ; the mental feebleness of many giants and the lethargy of the fat boy so well described by Dickens are easily recognized, and in cases of tumour of the pituitary associated with gross adiposity the sexual appetite may be quite abnormal. Surgical treatment of the cases due to tumour and medical treatment of those cases due to syphilitic infection may offer some hope of cure, but it is well to remember that most of the Fröhlich cases whose exact etiology is obscure, recover spontaneously at puberty or show so much improvement that they cease to be a clinical problem.

Most commonly the nervous manifestations are an indirect result of the endocrine disturbance. Excessive growth may cause shyness and a tendency to assume a stooping posture, whereas stunted growth may lead to a compensatory aggressive and even delinquent attitude. Such reactions are usually only of a mild degree and of themselves rarely sufficiently marked to be classed as pathological.

Adiposity in adolescent girls, so often associated with pituitary dysfunction, may be a source of psychoneurosis if the individual is teased about the condition. In such cases self-consciousness becomes morbid and efforts to reduce weight may lead to depression and irritability or even in rare cases to anorexia nervosa. This latter is a particularly interesting condition from our present point of view, because it shows so well the interplay between the nervous and endocrine systems. It occurs chiefly in young women and is in many cases a hysterical response to an unsatisfactory life situation—a dissociation of the alimentary system in an effort to attain some wanted end, either a plea for the sympathy which failure to eat produces or a desire for the interest and attraction which a slim figure is supposed to ensure.

Whatever the mechanism involved at the beginning of this condition it soon develops an impetus of its own. The diminished intake of food lowers carbohydrate tolerance and appetite disappears. The patient becomes emaciated and signs of vitamin deficiency develop. The mental attitude is one of restless activity and the protestations of good health are in striking contrast to the clinical appearance. It is impossible at this stage to convince the patient that she is in need of treatment, for she adopts to her physical condition all the indifference of the hysteric.

The pituitary function becomes affected early. Amenorrhoea and loss of libido is a constant feature and the body becomes covered with a downy hair whilst the normal hair tends to fall out. Eventually irreversible changes take place and the condition becomes almost indistinguishable from primary pituitary cachexia. It is obviously necessary to diagnose the condition early so that efficient treatment can be given. This must be both medical and psychological. The patient should be moved from the home environment, and firm handling and inexhaustible patience is necessary to induce her to take food so that the normal complex mechanism of appetite and digestion may be restored. Insulin and glucose and high vitamin feeding may be necessary in the beginning. Psychological treatment should be limited to persuasion and encouragement until recovery is sufficient to allow of co-operation and more specific treatment. It is better that

medical and psychological treatment should be given by the same person, if that is possible, so that the confidence established in the early stages can be utilized later to assist in the discovery of the psychological factors at work. Some degree of analysis and synthesis is always necessary to restore the patient to healthy living, and this may be made particularly difficult by the absence of a real incentive to recovery.

The differential diagnosis from Simmond's disease is not always easy, particularly in the later stages, but it is important that the distinction should be made both from the point of view of treatment and prognosis.

Primary pituitary cachexia occurs in older age groups (30–40 years) and commonly in multiparae. It may follow infection or trauma or be a sequel to post partum haemorrhage. Wasting may be severe but it is not always present. Amenorrhoea is constant and appetite is impaired though not completely lost and the patient is weak and listless in contrast to the restlessness of the patient with anorexia nervosa. The hair and teeth fall out and death is the usual sequel. Some cases recover spontaneously or after a pregnancy and there are almost certainly cases of less severity which never present the full clinical picture but may present psychological problems. Pathological proof of such cases must naturally be difficult to come by, but the following case illustrates such a possibility.

A young woman twenty-five years of age had a severe postpartum haemorrhage after the birth of her first child. She had previously been a plump happy woman devoted to her husband and her home. After the haemorrhage she became thin, angular and developed a shrewish disposition which she recognized herself but was unable to explain. Amenorrhoea persisted for many months and there was no secretion of milk. Five years later when seen again she had entirely regained her previous happy disposition and was normal physically. Her recovery had dated from a second normal pregnancy.

It is possible that biological tests will soon be adequate to establish the diagnosis in these cases and to differentiate fully developed Simmond's disease from anorexia nervosa.

The Thyroid.

It is very necessary to differentiate hyperthyroidism in which the patient is excitable, restless and emotionally instable from simple anxiety states. In the fully developed form this is easy, but there are some cases of thyrotoxic anxiety which present difficult problems, borderline cases showing only some tachycardia and palpitation without much in the way of physical signs, and it is in these cases that successful treatment depends on the recognition of the presence or absence of an organic background. One of the difficulties is that acute reactive anxiety causes a functional overaction of the thyroid and there seems good ground for believing that emotional factors, particularly those of sudden shock may produce irreversible changes in the gland, thereby producing a true thyrotoxic state. The possibility of this should therefore be borne in mind and both the anxiety and the thyrotoxicosis require attention; such cases frequently respond well to simple rest and sedatives provided that the anxiety can be relieved.

Psychoneurotic anxiety in contrast to the reactive type does not seem to affect the thyroid in this way, though the symptomatology may closely resemble that of Grave's disease.

The clinical differentiation between psychoneurosis and hyperthyroidism is important and may require a period of observation in hospital before a diagnosis is made. Observation of the sleeping pulse rate, the appetite and weight may be of assistance. Observations of increase of the B.M.R. in borderline cases of thyrotoxicosis is disappointing as the result is rarely sufficiently high to be of definite help. A lowered B.M.R. would, however, be in favour of psychoneurosis. Fortunately the history of the illness will often point to psychoneurosis and a number of clinical observations help in the diagnosis. The cold clammy palms and cool skin of the neurotic are very different from the warm moist skin of the thyrotoxic patient, and the tremor of the hands is of a coarser quality. The reactions to warmth and cold are also very different—so that it has been popularly said that the eiderdown is the crucial test; 'the thyrotoxic husband tends to throw it off the bed to the great annoyance of his psychoneurotic wife who wishes to keep it on.' There will remain

a few cases where the diagnosis is in doubt and the observation of the therapeutic action of iodine on the pulse after a period of stabilization is justifiable as a diagnostic procedure ; this is especially true in the older age groups when failure to recognize that the symptoms of emotional disturbance are due to hyperthyroidism may lead to serious myocardial damage.

Acute thyrotoxicosis is always associated with an excitable state of the nervous system, but occasionally acute mania or delusional insanity may complicate the picture. Where this occurs in a case without obvious enlargement of the thyroid, mistakes in diagnosis are liable to occur.

Myxoedema may be the underlying cause of a condition which might at first sight be attributed to emotional factors. Depression, apathy and undue fatiguability may suggest a true neurasthenia due to over fatigue, or an involution melancholia. Careful clinical examination should prevent such mistakes as these patients show the characteristic changes of thickening of the skin and loss of hair, sensitivity to cold and the 'stodginess' of the general appearance which should suggest the correct diagnosis ; there is usually some anaemia, and the rapid response to thyroid accompanied by iron will make the diagnosis clear. Even so, it is surprising how commonly the endocrine background is missed in these cases and a great deal of unnecessary invalidism is thereby caused. Apart from the general mental apathy and slowness of cerebration, severe myxoedema can be the cause of melancholia in chronic neglected cases, but such cases are rarely seen since effective treatment has been possible.

Cretinism is a rare cause of mental deficiency and requires energetic and persistent treatment with thyroid extract from an early age. Untreated cases seldom reach adult life because of secondary infections, and even with full treatment it is unlikely that complete normality can be attained. Half-hearted treatment may produce only sufficient recovery to change a child from a vegetative existence to one requiring severe restriction and control.

The Adrenal Glands.

Disease of the adrenals is fortunately rare, but when it occurs it may produce a state of true neurasthenia and

depression as part of the symptoms complex of Addison's disease. A full clinical examination and the blood chemistry will make the diagnosis clear so long as this possibility has been thought of. Successful treatment is fortunately now a possibility in many cases, but the prognosis will depend on the nature of the underlying lesion.

In the so-called adrenogenital syndrome, hirsutism, male distribution of hair and amenorrhoea may be complicated by frigidity or rarely homosexuality, but in such cases the endocrine cause is not likely to be overlooked. In some cases anxiety about the abnormal appearance may give rise to psychoneurotic symptoms. Many of the milder cases are compatible with a normal sex life and in a few cases, where the condition is due to simple adenoma of the adrenals, cure may follow surgical treatment. Treatment of the hirsutism of the face by electrolysis or depilatories is well worth while in the milder cases in order to minimise the psychological effects, and daily shaving is to be recommended when electrolysis is impracticable or depilatories are not successful. We are not yet clear as to the full pathology of these cases and it is probable that the changes in the adrenals are not the whole story. Recently Broster[1] has published some cases of adrenal disease complicated by a schizoid psychosis in which the mental state returned to normal after surgical treatment of the adrenals.

Feminization in males coming on after puberty is rare and is usually due to malignant change in the adrenals. No treatment is likely to be of value.

The Gonads.

The psychological difficulties of puberty are part of the problem of the psychoneuroses. Here the discussion will be limited to problems arising directly from the physical changes of this age. These changes need not necessarily be abnormal in order to produce psychoneurotic reactions; in girls for instance brought up with a faulty attitude to sex the normal development of the breasts may be a source of worry and may lead to a stooping round-shouldered stance designed to hide as far as possible the offending organs. It is to be hoped that

[1] Broster, L. R. 1944. *Endocrine Man.* London.

with saner upbringing of children such causes of anxiety will be eliminated.

Unrelieved anxiety about sex or ill-advised punishment for sexual offences at this age is liable to have a warping effect on sexual development and be the cause not only of inversion and perversion but of the lesser abnormal practices such as the insertion of foreign bodies per urethram and vaginam and other efforts at gratification dictated by curiosity and aided by a fertile imagination and ingenuity.

Homosexuality is only rarely due to gross disease in the endocrine glands and even disease of these glands associated with marked physical characteristic of the opposite sex may be associated with a normal or exaggerated heterosexuality. Obviously the sexual orientation of the individual must depend on factors more complex and fundamental than on the local conditions in the gonads themselves. In many cases the masculine type of woman and the effeminate type of man make satisfactory, though usually unfruitful marriages, and our ignorance of the problem in other cases where there is a homosexual tendency, makes it inadvisable to embark on surgical or endocrine treatment unless there is evidence of tumour formation or gross disturbance of function.

True hermaphroditism is so excessively rare that it hardly enters into practical consideration. Pseudo-hermaphroditism is relatively common, boys being brought up as girls more commonly than the contrary. In this condition there is only one type of gonad and the external genitals are not in conformity with this type. It is possible that the adrenal cortex plays an important part in the production of these abnormalities by the over secretion of androgenic or oestrogenic hormone, and the sexual orientation may be homosexual or heterosexual or in some cases ambisexual.

It is not uncommon in the testicular form of pseudo-hermaphroditism for the child to be brought up as a girl until puberty or even adult life, and in the ovarian form there are many recorded instances of girls reaching adult life as apparent males and even serving with distinction in the armed forces.

Every effort including laparotomy and biopsy should be made to establish a diagnosis in childhood because of the mental trauma associated with the late change over to the

opposite sex. If adult life has been reached and if a definite sexual orientation has occurred it would seem to be better to regard this as more important than the type of gonad present and to assist in reinforcing this sexual outlook by surgery and endocrine therapy. Unfortunately we are a long way from understanding what are the basic factors which determine sexual orientation and until they can be discovered and their mechanism is understood we shall be unable to deal adequately with this form of homosexuality. At present whatever success is achieved is limited to the group of cases of psychic origin or to the very rare cases where the homosexuality is due to a surgically accessible tumour of the adrenals ; the rest are best classified under the heading psychopathic personality and the problem of their management is more a social than a medical one, though the psychotherapist may do much to help them to adjust to their differences in life.

Sexual precocity may not be of anything more than medicolegal interest to the psychiatrist, but the child's difference from his fellows may constitute a psychic trauma. It may be due to tumour of the gonads, the adrenals, the pineal body or of the hypothalmic area. In the male, the infant Hercules is the classical type exhibiting this condition, and in girls, either virilism or early menstruation and other adult female characteristics may be seen. Treatment is only possible in cases due to removable neoplasm.

Nymphomania and Satyrism not due to some gross pathology are both beyond the reach of organotherapy at the present time and surgery can hardly be considered satisfactory treatment. Both may lead to promiscuity and prostitution and in their fully developed form are incompatible with successful marriage. The milder forms shade off in all degrees from normality and can be helped by the psychiatrist in two ways. He may, by explanation, remove much of the antipathy of the colder partner and, by advice, help the other towards some degree of sublimation of his desires. There is, moreover, a form of pseudo-satyrism—the Don Juan personality which is entirely psychological in origin and is a compensation for feelings of inferiority or in some cases a manifestation of a mother fixation. Such cases are eminently suitable for psychological treatment. Yet others developing later in life are due

to syphilitic or arteriosclerotic disease of the central nervous system with loss of the higher centres of control.

Many cases of frigidity in the female have an entirely psychological basis. The cause lies in years of faulty teaching and mismanagement of the early days of marriage. In some cases, however, an infantile state of the genitalia is present and such cases may be benefited by treatment with oestrogenic hormones. Not uncommonly these patients have a primary amenorrhoea and this in itself may cause anxiety. Explanation may relieve much of this anxiety and it may be justifiable to produce an oestrin withdrawal haemorrhage in order to allay the patient's fears. The failure of maturation may affect all aspects of adult sexual life; many of these patients are of a doll-like appearance with a desire to attract but with no genuine adult sexual feelings and there is no doubt that oestrogens can produce both general and local benefit in such cases.

Impotence is a distressing condition and is seldom due to endocrine disease. It is most often psychogenic and as such is not amenable to hormone treatment except where failure of normal sexual development has caused an anxiety which has led to impotence. Such a cause is not very uncommon in the male and if there is real underdevelopment, it is justifiable to treat the patient with testicular hormone to remedy the defects in growth of the penis, etc. Many such patients do not understand the wide range of normality in size of the genitalia and unnecessarily feel inferior owing to the smallness of their own. Absence of the testes as a result of trauma or disease is naturally the cause of much mental suffering and here too, treatment with testosterone or its synthetic equivalents is of the greatest value since it restores normal function short of spermatogenesis and the normal flow of ejaculatory fluid.

The impotence which is said to follow residence in the tropics is probably psychogenic and tends to disappear spontaneously shortly after return to a temperate climate. All cases must be fully examined clinically to exclude such general causes as diabetes, renal disease, malignant hypertension and chronic alcoholism, but if no disease is found the patient should be reassured. This in itself may be sufficient,

but some cases require psychological investigation and treatment. In some cases a guilt complex will be found associated occasionally with anxiety about the acquisition of venereal disease abroad, in others it is only necessary to interdict all efforts at sexual intercourse for a definite period of, say, three months, for it to occur normally within twenty-four hours of the prohibition. Presumably in such cases there has been an inhibition due to fear of failure.

The psychological disturbances of pregnancy are many and varied. Frequently there is a change of mood toward irritability or anxiety and marked depression is not uncommon.

Vagaries of appetite are common in the early months, and vomiting is so common as to be almost a normal event. Whether all such vomiting in the early months is psychogenic is doubtful, but certainly the great majority of cases in which it becomes a prominent symptom respond to a change of environment and removal from anxious relatives.

Adverse mental changes on the other hand are of more serious import and endocrine therapy is of no value in their relief. The milder cases of anxiety respond to encouragement and reassurance and can be helped with drugs which lower emotional tension, such as bromides and phenobarbitone.

The cases showing depression and alienation of affection from the husband should be treated with the greatest care. Because of the possibility of true psychotic depression, such cases should not be advised a holiday from home unless adequate arrangements for medical supervision can be made. There is a definite possibility of suicide and the question of termination of pregnancy will have to be considered, particularly when there is the possibility of obtaining a viable child by Caesarian Section.

Depression occurring during the puerperium calls for complete rest and quiet and the cessation of lactation. The mother should see her child only as much as she wishes and only then under supervision ; and it is advisable to limit the visits of the husband to such times as he may be asked for. In most cases institutional care is advisable.

The psychological effect of breast feeding and nursing is of fundamental importance to both mother and child.

In the first place it must be realized that women vary

greatly in the strength of their maternal instincts. In some it would seem to be almost absent and it is therefore absurd to insist that breast feeding is necessary to every mother's mental health. In most cases however, it is a source of deep psychological satisfaction to a mother to feed her child and every effort should be made to ensure that she can do so. Treatment with pituitary lactogenic hormones are of the greatest value in difficult cases but their use should not take precedence over attention to the more general causes of failure. Emotional upsets are the greatest barrier to lactation and should be avoided as far as possible. Above all the pernicious instruction so common at the present time that a mother should restrict her natural desire to fondle and nurse her child should be forgotten, and there should be a return to a more natural association for the benefit of both. Such teaching removes from the mother one of the most satisfying pleasures of life, and for the child such treatment may be disastrous to his future emotional development.

It is now realized that the basic security on which a child is to build his mental life is founded on the love which surrounds him in infancy and early childhood. A child who is denied this is denied the birthright which should give him not only a firm foundation for living, but also the use of that currency of affection which is the most important exchange of social existence. Nothing can entirely compensate the infant and young child for the absence of affectionate care in the first months and years of his life, and studies amongst children brought up in orphanages have shown that they do not know how to respond to appeals to their affections and lack the emotional warmth of more fortunate children reared under good home conditions.

The oestrus cycle produces in many women, to a greater or less degree, alternation between depression and elation. Usually the depression begins a day or two before the period and would seem to be of endocrine origin as it begins before any real pain or discomfort. Some women are irritable, short-tempered and unreasonable for a few days, but such cases do not present psychological problems and an explanation of the origin of these symptoms and some extra tolerance by those around is all that is required. In rare cases a confused state

may occur which requires reassurance, otherwise an anxiety state may be superimposed. Nevertheless some women are not quite normal and sure in their judgments during some days of the month.

It is interesting to note that in the case of amenorrhoea, although the oestrus cycle does not appear to be functioning properly it is quite common to find a mild cyclic type of depression.

The climateric mental disturbances are not necessarily closely related to the actual menopause. They may ante-date it or follow it by many years and frequent enquiry will elicit other symptoms particularly of vaso-motor origin which accompany the psychological disturbance. Being a period of change and therefore of instability, it is a time when underlying psychotic trends may make their appearance. These have been dealt with elsewhere. Apart from these, psychoneurotic symptoms are common and due in many cases to the many problems of growing older.

Regret for ' dear times waste ' and the prospect of declining activities may well, in a woman for whom physical attraction has been a major preoccupation, or in a man to whom athletic prowess has been the chief thing in life, lead to some reactive depression, and there is no doubt that contraception often exacts its psychological price at this age when the chance of parenthood is no longer present, and regret and even remorse for lost opportunities voluntarily renounced, are felt consciously or unconsciously.

Women who have vocations of interest and emotional value outside the sphere of physical attraction are likely to fare better at this age than those whose way of life has centred on their decorative value, and similarly women who have had a full and satisfying family relationship are unlikely to fall victims to psychoneurosis at the menopause.

Irritability, outbursts of temper and sudden changes of mood are common at this time. Weeping for no conscious reason and feelings of impending catastrophe are often associated with vaso-motor disturbances and headaches which force the patient to avoid company.

Treatment of these cases is fortunately not difficult. Oestrin preparations, whether natural or synthetic, help to

remove both the vaso-motor and the emotional symptoms, and sedative drugs may help toward the same end. Elaborate psychotherapy is not indicated in these cases except where the symptoms are an exaggeration of pre-existing psychoneurosis, but general encouragement and explanation may be of great help to the patient. In some cases there is evidence of thyroid deficiency with mental retardation at this age and this will require appropriate treatment. Where there is a true depressive state which does not respond to treatment with oestrogens, shock therapy, probably by electric convulsions is the treatment of choice.

The question as to whether involution melancholia is a manifestation of an underlying cyclic personality or a separate disease is not yet settled, but it is probable that some at least of these cases, particularly those associated with adiposity are of endocrine origin and good results have been reported with oestrin therapy; a few cases appear to have benefited from adrenal cortical hormones, but it is difficult to assess the value of such therapy because of the tendency to spontaneous cure or remission, and the fact that they often exert a powerful suggestive effect.

CHAPTER VIII

THE PSYCHOLOGICAL ASPECT OF ORGANIC DISEASE

In this chapter will be considered the mental disturbances following the various forms of cerebral disease, congenital and acquired, the vascular and traumatic lesions, and those due to tumours, infections, toxaemias and food deficiencies.

A full understanding of these conditions is of the utmost importance to the psychotherapist, because in many cases of organic disease the symptoms closely resemble a psychoneurosis or psychosis, and therefore demand great care in diagnosis. Moreover, especially in organic cerebral disease recognized as such, there is frequently the need of psychological knowledge in order to assess the patient's capabilities, and to plan his education or rehabilitation. The main difficulties in diagnosis naturally arise in the early stages, and it is in such cases that failure to recognize an organic basis for the mental symptoms, may be fraught with disaster for the patient, particularly now that neuro-surgery offers the possibility of cure for many cases of tumour, and medical treatment has become effective in other types of cerebral disease. In these latter cases, however, irreversible changes take place in the course of time, and the patient, if not diagnosed early, passes beyond the reach of therapy. This is illustrated by the case of a young girl of twenty-three who was admitted to hospital for psychiatric observation with many of the symptoms of schizophrenia. She had become depressed and withdrawn from life somewhat suddenly during the previous two months, although prior to this she had been happy at work on her father's farm and was engaged to be married.

Neurological investigation including C.S.F. was on admission completely negative. Her withdrawal increased and except for brief intervals she refused to speak or attend to her own

needs. She would accept food from the nurses and indicated when she wished to empty her bladder or bowels. Although at first a diagnosis of organic physical disease was not made, it was at once obvious that psychotherapy could have no effect and no real transference could be obtained owing to the increasing withdrawal. After one month in hospital she began to deteriorate more rapidly, had attacks of unconsciousness, and at times did not recognize her relations.

Examination of the C.S.F. now revealed protein and globulin excess with some increase of pressure. Operation was performed and a rapidly growing glioblastoma was found for which nothing could be done and she died on the day on which she was to have been married. Had this been a case of a less rapidly progressive lesion, early diagnosis might have saved her life provided psychotherapy or other treatment for a purely mental condition had not been persisted in, without a sufficient regard for the change in the clinical picture.

When the patient's symptoms are of a psychotic type, the finding of an organic basis for the mental illness is generally of ill-omen for the patient, though it may be of comfort to the relatives since it removes the stigma and social complications which unfortunately still attach to so-called primary mental disease, and allows the abnormal behaviour to be more easily tolerated.

The difficulty of diagnosis is particularly evidenced when, as sometimes happens, the mental change has followed on, or has become prominent after some emotional trauma and when the symptoms are chiefly of a psychoneurotic nature. It should be remembered that true psychoneurotics will have a history dating back over a period of years, the symptoms seldom appear 'out of the blue', and it is almost always possible to base the diagnosis on positive grounds rather than by a mere exclusion of organic disease. Whatever the nature of the organic lesion it rarely acts alone in producing the abnormal pattern of mental reaction; age and previous education and endowment play important parts, and in many cases an underlying hereditary tendency such as is met with in uncomplicated cases of psychopathic personality, may be regarded as being released as a result of the disease process. Such sudden appearance of symptoms should therefore always

be regarded with suspicion and a careful physical examination or re-examination should be undertaken.

Congenital cerebral disease is usually accompanied by some form of mental deficiency and this has been dealt with elsewhere. Congenital aphasia and alexia, however, are not necessarily associated with any general mental defect, as intelligence tests will show; but, unfortunately, children suffering from these disabilities are frequently regarded as being mentally defective because of their difficulties of specific understanding or expression. This is particularly the case in those patients who, suffering from aphasia, develop idioglossia; the resulting mismanagement of the supposed mental defective inevitably produces abnormal psychological reactions and gross backwardness. The aphasia is usually of the receptive type and is first noticed in the second or third year; alexia may be associated with it or occur independently. In the latter case no abnormality is discovered until the age at which the child normally begins to read and write. Thomas[1] found alexia in 1 in 2,000 London school children, and the condition is sometimes familial. In both cases treatment must be in expert hands, the physician's main duty being to recognize the true nature of the conditions and on the one hand to prevent the child being placed in an unsatisfactory environment, and on the other to ensure proper treatment, including that of the psychotherapist and speech therapist.

Some cases of cerebral palsy, especially if associated with athetosis, are often mistakenly thought to be mentally defective and are not therefore educated although their general intelligence may be quite good. The work of Phillips in America and the Carshalton unit in this country have shown how much can be done for these children by combined physical and mental training, and the help of the psychotherapist is often required to correct the effects of early neglect and mismanagement.

In congenital syphilis, there may be little or no objective evidence of organic disease; it may show itself simply by causing backwardness at school and disturbances of behaviour. When these disturbances are pronounced, the possibility of congenital G.P.I. should be considered, although in many

[1] Thomas, C. S. 1905. *Ophthalmoscope*, iii., p. 380.

such cases epilepsy with its manifold convulsive equivalents will be more often found to be the cause.

In general it may be said that in young people a simple dementia, that is, a progressive lowering of intelligence, is most likely to be the result of organic cerebral disease, and may proceed to its fatal termination without much disturbance of general behaviour. This may happen in the case of tumours, or of demyelinating diseases, or of some forms of encephalitis, though in encephalitis lethargica there may be a remarkable change in personality with pronounced aggressiveness and delinquency. These changes may be diagnosed as a psycho-neurotic reaction and attempts made to deal with it by psychotherapy. While some psychotherapy may be required, and rehabilitation is essential, in most cases of post encephalitic personality changes dealt with during the epidemic of the 1920's, the results have been disappointing and much time and effort were expended without achieving any success.

In adults, dementing processes as a rule cause marked alterations of character and behaviour. This is inevitable when the very different medium in which the degenerative process works is considered with all the added emotional and intellectual material which may be disturbed.

It may be said at once that there is no specific association between a given type of cerebral disease and any particular abnormal mental reaction. Diagnosis of the type of lesion will depend in every case on a full assessment of all the available evidence—the age of the patient, the history of the illness and any associated physical signs together with the results of specialized investigations. It is true that in some cases a clinical picture is so commonly observed in conjunction with a particular causal agent that a special association between the two may be assumed ; thus encephalitis lethargica in adults is frequently followed by brady-phrenia, brady-kinesia and tremor, and by aggressive personality changes in children, while chronic alcoholism tends to disturb orientation of space and time. In G.P.I. there is a special tendency for time relations to be lost, but such associations are not inevitable and other forms of cerebral disease may exhibit the same symptoms. Thus the traditional assumption that patients exhibiting ideas of grandeur are almost certainly

suffering from general paralysis and that all general paralytics have such delusions is emphatically not true.

In general it may be said that organic disease manifests itself by the physical signs it produces and by some form of dementia, using that term in a wide sense to include the abrogation of any normal process of mental function, cognitive, affective, or conative. In many cases all the aspects of mental life are affected equally and there is an approach toward a vegetative existence. In others there is a general failure of intellectual capacity associated with loss of memory and feelings of inadequacy—'a plentiful lack of wit'. In others the general executive capabilities are most affected and we find a general gaucheness in the performance of the simple movements of dressing and feeding.

When the affective side is most interfered with, we may find a loss of the normal emotional responsiveness to the tribulations and joys of life, a loss of affection for close relations, or of moral sensibility. All such results are essentially of a negative nature and are easily understood on the basis of partial degeneration, or destruction of cortical tissue. They may occur together in any combination of kind or degree. Other cases, however, are not so easily understood on this simple basis. Not only are they more complex, but so far from showing a loss they actually appear to show marked exaggeration of some aspect of mental function, especially in the emotional field.

In order to understand the genesis of these difficult cases it is helpful to use Hughling's Jackson's concept of disintegration of mental functioning. Paterson[1] using the Gestalt hypothesis, has extended the idea to include not only cognitive, but affective disturbances also.

If we consider normal mental functioning as being the result of a central field of consciousness standing out in relief from an unconscious but related background, this abnormal mental functioning may be due to :

(*a*) A narrowing and restriction of the central field.

(*b*) Loss of, or distortion of the background.

(*c*) Attachment of a normal or restricted field of consciousness to an unrelated background.

[1] Paterson, A. 1942. *Lancet*, ii., p. 717.

It is inadvisable and useless in the present state of our knowledge to speculate on the physio-psychological mechanism of these changes but the assumption of such changes as a working hypothesis does seem to correlate what would otherwise be a great diversity of apparently unrelated clinical pictures. It is not difficult to see how confusion, for instance, can result from a narrowing of the conscious field by organic changes, so that only one attribute of a seen object may be understood—the man who mistakes a pencil for a cigarette because his appreciation is limited to the shape of the object. Affective disturbances may result from deviation of an affect to an irrelevant object or because it becomes isolated from its normal restrictive background and from the balancing effect of opposing forces. It is possible that the ambivalence of emotion explains, or rather offers a working hypothesis to enable us to picture the reversal of affect so commonly seen in mental illness.

Paterson cites two cases which illustrate very well the affective changes which may follow cerebral injury with consequent lack of restrictive background. In one the personality was changed from one of comparative stability to one of excessive timidity and shyness, attributes which though present before had always been successfully masked. In the other case of a soldier, aggression which had previously been kept within bounds as a result of military discipline and which had served to make the patient a very efficient soldier, became, after a cerebral injury with consequent loss of his acquired restrictive background, of pathological intensity. In a third case, a woman suffering from a cerebral tumour transferred all her affection from her husband to her mother and later, as the condition advanced, back to the husband again.

Similarly, hallucinations and delusions may be brought into the same scheme. Thus we may consider them as ideas originally founded in reality which become divorced from their restrictive surroundings and acquire haphazard relationships. They then emerge as concepts entirely unrelated to reality.

Bearing in mind that there is no specific association between any pathological process and any particular syndrome it is

not surprising that clinical pictures due to some organic lesion may closely simulate those due to emotional conflict and disturbed attitudes to life. Hence the great importance of careful diagnosis before any specific course of treatment is undertaken. In order to assist in diagnosis it is worth while to review some of the effects of organic cerebral lesions and to discuss their more probable manifestations.

Trauma.

Apart from a localized disintegration of function such as aphasia, agraphia and various forms of paralysis this may produce a lesion with resulting personality changes. In some cases twilight states similar to the semi-conscious condition seen after encephalitis, which may be mistaken for hysterical states of 'mental eclipse', may bring the patient into the hands of the police. Again, even after a simple concussion, a patient may have a fugue in which he wanders away having 'lost his memory' and which is only with difficulty distinguished from that seen in hysteria or from the post epileptic automatism. There seems little doubt that repeated cerebral injury such as that sustained by professional pugilists may cause a condition very much like post-encephalitic parkinsonism. Depression is not uncommon and may lead to suicide. It is probable that some of these phenomena represent an outcropping of a previous tendency which has been released by the cerebral injury. Post concussive depression may be differentiated from psychoneurotic depression by the fact that amusement is as intolerable as work in the former case, but may be sought as a relief in the latter although by no means always effective. Psychoneuroses are, of course, common following trauma, particularly when the question of compensation arises. But as Paterson has pointed out it is difficult to differentiate such cases from those in which anxiety is the result of an organic disintegration of stabilizing influence.

Alcohol has a particularly bad effect on patients who are suffering from the effects of cerebral trauma. Even small amounts exert exaggerated effects in such cases and may give rise to the suspicion of quite different mental disease. It may be the cause of behaviour which lands the patient in the police courts. Such people should be strongly advised to

abstain from alcohol altogether, and care has likewise got to be taken to protect these patients from undue fatigue.

Rehabilitation is the key-note of treatment in traumatic cases, and the question of compensation should be settled as soon as possible and should then, in the case of most patients, be followed by psychotherapy designed to readjust them to normal activity; this may involve no more than encouragement and reassurance. The establishment of the Disabled Persons' Register should help these persons very materially since one cause of anxiety is the fear of unemployability. Many cases show persistence of symptoms and pass from a post-concussive state into a true psychoneurosis. Investigations will show that the neurotic illness is serving other ends than those directly connected with the accident. Thus a woman who was badly adjusted in her marriage showed severe psychoneurotic symptoms after a motor accident. In spite of adequate compensation her symptoms persisted until her underlying marital difficulties were discovered and resolved. Very often a severe accident is a godsend to such people as it provides an adequate and ' respectable ' reason for the release of an underlying psychoneurosis and the psychotherapist must not be content to attribute everything to the accident if he is going to do good.

On the whole, the ultimate prognosis of patients showing mental symptoms after cerebral injury is good, and the whole condition clears up as a rule, though some cases develop epilepsy and suffer lasting disability therefrom. This disability is not only represented by the epileptic fits, but also by the mental accompaniment of these. Russell Brain suggests that under 5 per cent. develop this complication and that it is most likely to occur in trauma involving penetration of the surface of the brain. The latent period may be anything from a few months to many years. In many of these cases there is already a family predisposition to epilepsy as shown by the history or by electroencephalographic investigation of the patient or other members of the family, suggesting the pre-existence of a congenital cerebral dysrhythmia. After trauma therefore, the psychotherapist has an important but difficult part to play since he has to distinguish between those parts of the complex clinical picture due to irreversible cerebral

changes, and those from which his art is capable of promoting recovery.

Alcohol.

Chronic alcoholism is of special interest to the psychotherapist. It not only forms the basis of much disorganization of cerebral function, but is in itself a symptom of many mental illnesses, and its investigations and treatment is sometimes a very difficult matter. It must be remembered that the milder forms of over-indulgence are quite compatible with a very adequate social existence and such cases may not require treatment. The patient is, so to speak, in a state of satisfactory equilibrium as a result of, or rather with the help of, the alcohol. This is particularly true of the mild 'excesses' seen in late middle age. How far such over-indulgence even though mild, may shorten the duration of full mental efficiency, is still however a matter of doubt.

The manifestations of chronic alcoholism in the earlier stages are very variable, though towards the end a state of chronic dementia is common to all.

In the earlier stages slight changes in personality, loss of previous standards of conduct and responsibility, increase of irritability and general diminution of emotional control together with loss of memory and initiative are found. These symptoms frequently cause a demand for psychotherapeutic services and if the influence of the underlying alcoholism, which is frequently carefully hidden is not realized, much time and trouble will be wasted. In many cases there is some increase in libido together with an associated impotence, and this in an atmosphere of family discord, itself the result of the patient's behaviour, may give rise not only to much marital unhappiness, but even to delusions of infidelity. Sometimes a chronic subdural haematoma due to injury sustained during a drinking bout may cause a changed personality, associated with headache and periods of stupor which may be mistakenly thought to be the direct effect of alcoholism if the condition is not borne in mind.

In more advanced cases the Korsakoff syndrome may appear either fully developed or limited to slight confabulation about times and places; in other cases the confusion is more general.

Emotional lability is a specially common feature in these patients, and the illness may be interrupted by attacks of delirium tremens. These latter attacks, because of their terrifying nature, are commonly the cause of periods of temporary abstinence, and advantage should be taken of them to institute effective treatment when possible. A euphoric state indistinguishable from that met with in G.P.I. is sometimes seen, and if found in association with tremor which is so constant in some alcoholic states, may necessitate serological investigation before a diagnosis is established.

The causation of some cases is fairly simple, environment and opportunity combined with an absence of sufficient interest in the business of living bring about the patient's downfall. This was well seen in West Africa during the war when many men found relief from boredom and frustration in a state of mild chronic intoxication, which soon became a habit only broken with great difficulty.

Other causes are to be found in efforts to relieve reactive anxiety or in attempts to out-do others in what is stupidly regarded as a 'manly' characteristic and to compensate a profound feeling of insecurity. The result of treatment of such cases depends chiefly on the co-operation of the patient and the personality of the psychotherapist. If these are favourable the prognosis in young people is good. Disgrace or bereavement may be sufficient to bring about a desire for cure and lead to temporary abstinence during which the psychotherapist can lay the foundations of a more satisfactory permanent adjustment. Treatment must inevitably be prolonged as the patient must be given an entirely new orientation and a worth while object to which to look forward.

Other cases have their origin in more deeply seated psychological difficulty or in a psychopathic inheritance, and alcoholism is not infrequently a symptom of early psychosis, particularly the depressive phase of cyclothymia. Deep analysis may hope to benefit some of these cases, but in most it is disappointing. Sporadic attempts at cure may be made by the patient, but they are short-lived. In many cases the best that can happen is, that advantage should be taken of lucid intervals to persuade the patient to make such legal

provision as will prevent his wife and family from becoming destitute.

Age has an important bearing on the prognosis in every case. There is little prospect of cure in elderly people who resort to alcohol as a means of relieving the emptiness that they are liable to find on retiring from active work. It was interesting to see how a return to work during the war years benefited a number of these patients and in others the interest of the war itself was sufficient to cause a general improvement. No doubt the difficulty in obtaining alcoholic drinks was a factor in some, but certainly not in all.

The alcoholism seen in some women at the menopause has, as a rule, a good prognosis, particularly now that endocrine treatment at this age has become possible, and convulsive therapy can relieve them of their depression, but the psychotherapist is generally required to assist the patient to a new purpose in life without which little happiness and therefore little health can be expected.

The length of time during which the patient has been suffering from alcoholism is of great importance because in course of time irreversible changes take place in the nervous system and a state of chronic incurable dementia results.

In all cases medical treatment designed to improve the general health is important as a basis for psychotherapy. Fresh air and interests out of doors are necessary and should be combined with a nourishing though light diet and with vitamin B preparations, preferably, in the early stages, by parenteral routes. Sedatives should be given freely for sleeplessness and anxiety. In all cases it is advisable that the patient should be treated away from home, if possible in an institution where he can be given congenial occupational therapy as part of his psychotherapy. Unfortunately such institutions are beyond the means of all but the more wealthy, particularly considering the length of stay necessary for complete cure. In the cases where the patient is employed in the liquor trade a change of vocation is essential.

Avitaminosis.

Chronic alcoholism is intimately bound up with deficiency of vitamin B, but the latter condition is seen apart from

alcoholism and, because of the profound effects on the nervous system, it will be considered here. Its importance lies in the ease with which it may be misdiagnosed.

The vitamin B complex, particularly thiamin and nicotinic acid, is necessary for normal metabolism in brain tissue. The result of its lack will depend to some extent on whether the deficiency is acute or chronic. In the former case, treatment is strikingly successful, but in the latter irreversible structural changes take place in the brain.

The acute cases of nicotinic acid deficiency may be the result of dieting for gastro-intestinal disease or of severe toxaemias or exhaustion states which make an added call on metabolism, particularly when nourishment is limited to intravenous therapy. Fevers, by making an increased demand on metabolism may also be responsible, but in these cases it is probable that the patient was on the borderland of avitaminosis previously as a result of alcoholism or starvation. Cases of mild vitamin B deficiency were very common as the result of war dietary and an extra supply of this vitamin helped the psychotherapist in the restitution of many patients who were suffering from some degree of true neurasthenia (fatigue state) rather than from true anxiety.

Clouding of consciousness, delirium and hallucinations are the usual mental symptoms and respond within a few hours to treatment with nicotinic acid. Another class of acute vitamin B deficiency has been noticed (Sydenstricker, 1939)[1] in elderly undernourished subjects. The patients alternate between profound stupor and delirium, and are usually considered to be suffering from cerebral thrombosis, or uraemia, or in cases where bodily weakness is more pronounced from cardiac failure. Untreated cases die of broncho-pneumonia, but the results of treatment may be remarkably good if the process has not gone too far.

Yet other cases have been described in alcoholic subjects showing evidence of pellagra, and a lesion in the mid-brain and peripheral nerves has been found. In such cases it is suggested that nicotinic acid treatment should be supplemented with other parts of vitamin B complex.

[1] Sydenstricker, V. P. 1939. *Jour. Amer. Med. Ass.*, pp. 113, 1697.

The manifestations of chronic deficiency are seen most commonly in alcoholic subjects, because alcoholic gastritis prevents the absorption of vitamin B in patients suffering from gastro-intestinal disease and from anorexia nervosa. The symptomatology may simulate psychoneurosis very closely. Anxiety, loss of concentration and memory for recent events may precede physical signs of pellagra for many months, and Sydenstricker mentions insomnia, headache, vertigo and paraesthesia as indicative of early organic change. Later depression or a paranoid state may be produced.

Treatment must be intensive and authorities recommend 100 mgms. of nicotinic acid given hourly by parenteral injection for ten hours in the first two days followed by 500 mgms. a day, and then a maintenance dose of 25 mgms. t.d.s. orally. Later treatment for the underlying alcoholism, if present, should be carried out and a proper provision made for adequate dieting.

Drug Addiction.

Much that has been said about the cause of alcoholism is true of drug addiction. The latter is, however, more commonly the manifestation of a psychopathic personality and therefore less amenable to treatment. A small proportion of morphine addicts show good results where the addiction is due in the first place to the unwise use of the drug over a period of not too long duration for the relief of pain, or in the treatment of spasmodic asthma.

Moral rather than intellectual deterioration is the commonest sequel and the general health suffers severely as a result of the necessary attempts at withdrawal rather than as a result of the intake. As a rule there is no difficulty in diagnosis once the condition is fully established.

Prophylactic treatment designed to make the drug inaccessible by social legislation is not entirely successful. Some cases could be prevented by its more judicious medical use only as an analgesic or vagal depressant, and in this connection it is not generally realized that its use as a hypnotic is always harmful unless the sleeplessness is due to pain or cardiac failure, and even then sleep may only be procured by the use of real hypnotics in addition.

Treatment must always be institutional, though unfortunately the doctor is not in a position to enforce this, and a long period of rehabilitation through occupational therapy is necessary before the patient returns to ordinary living. Psychotherapy must be combined in the fullest way with medical treatment if good results are to be obtained and co-operation of the patient is essential. On the whole, however, whatever is done, the outlook from the point of view of permanent cure is not good.

Bromism.

Among the less common causes of mental symptoms, bromism deserves mention, because it may complicate the treatment of some other mental illness, and unless recognized can cause serious difficulty and even result in the transfer to an institution of a patient with a simple anxiety state.

The condition should be suspected when a patient under treatment with bromides becomes confused or markedly depressed, and if he suffers from the characteristic rash or from gastritis, there should be no doubt of the diagnosis. There is nothing characteristic about the mental state and almost any of the organic reactions can occur. The diagnosis is easily confirmed by estimation of the blood bromine and by the response to stoppage of the drug and the giving of sodium chloride.

Carbon Monoxide.

In cases of attempted suicide by this means an organic reaction may become superimposed on the primary mental upset which induced the attempt. This may take any form, but conditions similar to post-encephalitic parkinsonism or a Korsakoff syndrome are common. More chronic poisoning is an occasional cause of a psychoneurotic state and is seen particularly in motor-car drivers who have inhaled fumes from a leaking exhaust pipe. In such cases, a period of rest is all that is required in treatment, but the diagnosis presents difficulties unless the possibility of poisoning from this source is borne in mind and specific enquiry made.

Syphilis.

This disease causes mental symptoms not only as a result of infection of the nervous system, but its dread significance

may be the basis of an anxiety state following exposure. In the latter case the cause of the anxiety is seldom expressed by the patient and the physician must go more than half way to elucidate it. Such patients commonly present themselves with symptoms of some functional illness and trust the physician to confirm or relieve their fears as a result of routine examination. It is therefore necessary to keep the possibility of this cause, whether it be real syphilitic infection or anxiety lest such be present, or both, always in mind when investigating psychoneurotic illness. Complete relief may follow if, as a result of examination and a blood test it is possible to give an unequivocal reassurance. In the case where relief does not follow, the condition is a guilt fixation coming under the heading of true melancholia and will be extremely difficult to treat even with the help of deep analysis or convulsant therapy. It must always be remembered that symptoms indistinguishable from those of psychoneurotics are found in early cerebral syphilis.

The symptoms of syphilitic involvement of the brain are those of any other organic involvement. The chief problems arise in the early stages when the symptoms may be of a psychoneurotic nature ; anxiety and depression and feelings of inadequacy and fatigue may be the heralds of symptoms more obviously connected with cerebral syphilis. It has already been noticed that, in children, waywardness, backwardness at school and emotional outbursts may be the only manifestation of juvenile G.P.I. or cerebral syphilis.

The psychotherapist's chief responsibility lies in achieving a correct diagnosis in these cases, remembering that early organic changes and emotional disturbances may produce much the same symptoms. With regard to adult G.P.I., though the euphoric type of reaction is the one traditionally connected with this condition, it is by no means a necessary association and the idea has probably done harm by standing in the way of early diagnosis. Depression, moral degeneration, ideas of persecution or simple dementia, are all quite commonly seen. There is no condition which better illustrates the necessity of a complete physical examination of every case presenting mental symptoms or indication of disorder of the nervous system. Now that pyrotherapy or malarial infection

offer a prospect of arresting the condition, it is of the greatest importance that early diagnosis should be made. In later cases, particularly those showing euphoric symptoms, it may be necessary to certify a patient in the early, rather than in the late stages of the disease, in order to prevent him from ruining himself or his family.

Disseminated Sclerosis.

This is of importance to the psychotherapist, not so much for the benefit he can be to the patient, though this may be substantial, but because of the difficulty in differentiating the early symptoms from those of hysteria. Physical signs may in the early stages, be minimal, and moreover, the symptoms may apparently show definite response to psychological treatment though it is probable that such a response is often due to a coincidental remission.

Throughout the illness much good can be done by proper psychological handling of the patient; therapeutic nihilism is to be condemned, and stress should be laid on the prospect of the long remissions which undoubtedly occur in this disease.

Fortunately many patients seem to be little troubled about their condition and may even be euphoric; others, however, suffer from severe depression and require constant encouragement. Physiotherapy and occupational therapy help considerably and the patient should be kept up and about for as long as possible.

In all illnesses causing physical disability and especially in those which produce restriction of movement, we must consider the feeling of frustration produced quite apart from any primary effect on the cerebral cortex. This will be specially marked in the aggressive and energetic type, and the physician must consider the psychological as well as the physical condition of his patient.

Encephalitis Lethargica.

This condition offers a difficult problem to the psychotherapist particularly in those cases, chiefly in the younger age groups, where moral deterioration and conduct disorder is a prominent feature. It is well to remember that many such cases in juveniles may not show much in the way of

physical signs of disease, so that the outbursts of temper and viciousness may not be ascribed to their true cause unless a careful history is taken. For the worst cases institutional care is necessary.

For patients who show depression and parkinsonism, however, some good can be done by psychotherapy, and successful rehabilitation may be possible in mild cases, so that the patient who was formerly a trouble to himself and others becomes fitted for a useful occupation. Occupation and encouragement are the sheet anchors of successful therapy, and this can be helped by continuous medication with hyoscine, belladonna or other drugs. Not only do these drugs improve the muscular condition but they stop the excessive salivation which is so distressing a feature of some cases.

Cerebral Tumour.

Apart from manifestations due to the influence of the tumour on surrounding structures, general personality changes are common. In the case of slowly growing tumours the onset of mental changes may be insidious and an organic basis may not therefore be considered. Subdural haematomata in particular may cause difficulty in diagnosis especially as there may be no history of severe head-injury, and it is not an uncommon thing for these patients to be sent into mental hospitals with a diagnosis of dementia or psychotic illness. In the case of frontal tumours, slight changes in disposition, a blunting of sensibility, general facetiousness or sexual offences may appear without evidence of gross cerebral disease.

The predominant note in cerebral tumour is retardation rather than excitement, and somnolence rather than wakefulness. Indeed it is usually said that insomnia should by itself cause doubt as to the correctness of the diagnosis of tumour.

The importance of establishing an early diagnosis is obvious and there should be no serious difficulty if the possibility of the presence of organic disease is borne in mind in the investigation of every case of mental illness and, where there is serious doubt, full investigation by electroencephalography and ventriculography is undertaken.

Cerebral Arterial Disease.

This is probably the commonest cause of organic mental illness, certainly in the older age groups. Because it is beyond the reach of treatment it is frequently thought to be unimportant, but it is the cause of a tremendous amount of unhappiness and therefore deserves serious consideration.

The change in personality that may follow arterial degeneration frequently causes all the difference between a benign old age and one of suspicion, selfishness and unfair dealing. Not suspecting what they call real illness, the relatives frequently call upon the psychotherapist to cure the patient. In such cases the question of testamentary capacity frequently presents serious problems to the physician and still more serious ones to the family.

In some cases the clinical picture is complicated by alcoholism and it is difficult to assess the relative importance of the two factors.

One of the chief difficulties, as stressed by Mapother and Lewis, is that the patient continues to look normal and sensible, though he is definitely demented. Episodic disturbances and twilight states and hallucinosis are occasionally described.

Frequently there is a family history of arterial disease and in many cases evidence of local cerebral vascular disease precedes the mental change. Disturbances of emotional expression such as laughing and crying without reason and without concomitant emotional feeling may cause much unhappiness unless the nature of the condition is explained to the relatives, and a slight degree of aphasia is commonly a source of suffering to the patient unless he is made to realize that his difficulty is understood and appreciated. Such cases are not amenable to any form of psychotherapy more complex than encouragement and general management, and they should not be allowed to waste the time of the specialist once the diagnosis is established.

The Toxaemias.

The toxaemias resulting from acute systemic infection may directly affect the brain and cause various degrees of confusion and delirium. Such cases are not liable to cause much

difficulty in diagnosis even though the exact nature of the underlying infection is not apparent. It is quite otherwise, however, with the more chronic infections such as pulmonary tuberculosis, abortus infection, etc., which show themselves by producing a neurasthenic or psychoneurotic state, and the depression and weakness following the more severe infections may not always be ascribed to their true cause.

There is no doubt that true neurasthenia can be of purely psychic origin and it is not uncommonly seen after prolonged emotional strain or after bodily or mental exhaustion, but when such causative factors are not obvious, careful search must be made for foci of sepsis—not the small cryptic foci of infection so popular in the last decade, and so often the product of enthusiastic research among the flora of various channels of the body, but definite sepsis such as dental abscesses, purulent sinuses or chronic pyelitis. If fatigability is a prominent symptom, smouldering pulmonary tuberculosis should be suspected and ruled out by x-ray examination, and a period of observation in bed is advisable in order to exclude more general infections. When over-fatigue is the cause, rest in bed with sedatives and light carbohydrate feeding is all that is required so long as further emotional disturbance is excluded.

Apart from chronic infective processes other sources of toxaemia must receive consideration. In particular, metabolic disturbances such as diabetes and liver deficiencies, especially in children in whom impaired carbohydrate metabolism may cause depression and instability ; a mild degree of myxoedema or hyperthyroidism may very easily produce almost identical symptoms, but the endocrine causes have been considered under a separate heading.

Gout as a cause of depression and irritability has lost the importance it once held, but should not be forgotten as its diagnosis is sometimes missed in these days. Uraemia, however, deserves special mention because in the early stages it is so often unsuspected. It is said to be a ' disease of surprises ' and there is no doubt that it presents in many unexpected forms. It may first cause mental symptoms—the *folie Brightique* ; Korsakoff's syndrome may appear or euphoric dementia like that so often associated with G.P.I., while other cases show simple dementia or confusion lapsing into stupor.

A consideration of all the possible organic causes of mental symptoms, psychoneurotic or psychotic, cannot help but underline the arguments so often brought forward against lay psychotherapy.

Even with medical knowledge the psychotherapist is bound to make mistakes from time to time, but the tragedies of missed diagnosis that would occur without such knowledge, would go a long way toward bringing psychotherapy into disrepute. Nor is one preliminary examination by a physician a complete guarantee against missing underlying organic disease ; it may be necessary to review the condition from time to time if absence of improvement or altered symptomatology suggest it, but the suspicion that all is not well may not readily occur to the mind which has not been medically trained.

CHAPTER IX

PSYCHOTHERAPY IN THE TREATMENT OF THE PSYCHOSES

In the early days of psychotherapeutic enthusiasm, it was thought that some positive method of treatment might have been found for the psychoses. A great deal of work has been done, and a great deal of valuable light has been thrown on the way in which symptoms arise and develop in these conditions, especially in the case of the schizoid group including paranoia.

A number of ingenious theories have been formulated to explain the remarkable symbolization, distortion of affect and regression to infantile behaviour, which underlies the bizarre symptoms of schizophrenia and certainly they seem to fit the picture reasonably well, but there can be no doubt that the therapeutic results of the application of these theories have been, on the whole, disappointing.

Claims were made that schizophrenics, manic-depressives and even paranoiacs were cured by the application of these theories, but remission is known to occur in all these conditions, apparently spontaneously, and it is doubtful whether such remissions were either determined or increased by psychoanalytic procedures. Had the practical results of the application of these theories proved as convincingly successful as their authors hoped, many more people would have accepted them, but because cures were not certainly effected, this does not prove that the theories themselves are untrue, though they may not be complete explanations of the genesis of these conditions.

Before considering the usefulness and limitations of psychotherapeutic procedures in the treatment of the insane, a few generalizations as to the nature of the various types of the psychoses may lead to clarification.

In the first place it is well to put on one side the dementias, which are due to degenerative diseases of the brain, over which we have very little therapeutic control once they have started. Still, were the preventible acquisition of syphilis, the abuse of alcohol and whatever factors determine arteriosclerosis eliminated, there is no doubt but that the incidence of dementia would be very much reduced, or at least its onset postponed till much later in life—a very important matter, since the average age of the nation is steadily increasing.

Next we have the confusional states, generally associated with toxins, whether bacterial or chemical, or with fatigue. This group may be broadened to include G.P.I. since this disease is due to infection with the spirochaeta pallida.

It is a noticeable fact that only quite a small proportion of syphilitics acquire G.P.I. and only a very small proportion of parturient women develop puerperal or lactational insanity, perhaps the most typical examples of confusional states; prolonged confusion only occasionally follows pyogenic infections, while only a few alcoholics or drug addicts manifest definite psychoses.

It would seem possible, therefore, that only those individuals develop confusional states, who are psychopathic personalities, especially of the schizoid and cyclic types, and that poisons and fatigue only act as precipitating factors on a soil already potentially ready to develop a psychosis. It is not, of course, intended to imply that all confusional cases are potential schizophrenics or manic-depressives, but it would seem likely that quite a significant number of them are, since even in such a relatively concrete disease as G.P.I. we get elated, depressed, secretive and suspicious patients. The same variation of reactions may be seen in puerperal cases and in alcoholics, but more research is needed before such a simple explanation of the genesis of confusional states can be accepted as true. In any case, in none of these conditions can psychotherapy be usefully employed while the confusion lasts.

It is, however, in the treatment of schizophrenics and of manic-depressives that psychotherapy has its place, if at all, and so in confusional states it may be possible that, once the toxic factor has been removed these patients can be treated by this method.

So far as psychotherapy is concerned, it may be taken that no such treatment is possible when the psychotic is in a severe and acute stage of his disease. Whether he is confusional, in manic excitement, in deep depression with a profound sense of sin, stuperose, entirely lost in phantasy, catatonic or violently suspicious, he is quite incapable of co-operation in his treatment and any attempt at psychotherapy or any other rational approach is a waste of time and breath.

This is the time, at which physical remedies are effective in certain cases, but anything approaching 100 per cent. of success must not be expected, in the present state of our knowledge, from any method. Such physical methods include detoxication and removal of the underlying infection in the toxic confusionals and prolonged rest and feeding in the exhaustion cases. This treatment is often helped by the administration of insulin and glucose. The exhibition of endocrine preparations may be tried in the manic-depressive cases, especially if there is a definite indication of a shortage of any particular glandular secretion, although success has been claimed for mixed gonadal extracts, without any very clear rationale for such treatment. Shock therapy has proved successful in the treatment of some early schizophrenics and depressives, insulin in other schizophrenics and sedative baths and prolonged narcosis in the manics.

When these remedies have done their work, or the natural course of the disease has produced a remission, the patient may then be in a sufficiently approachable state to make other treatment including psychotherapy worth while.

The school of Adolf Meyer, while by no means neglecting psychotherapy, pins its faith on well-directed occupational therapy, whereby the patient is rehabilitated and gradually brought back to face the demands of life in society.

The analysts and others consider that, while occupation is advisable, chief stress should be laid on giving the patient insight into his condition and if possible removing the conflicts and inhibitions which they believe to be responsible for the disease. Even so, however, these authorities generally agree that these conflicts and inhibitions are very deeply seated in the psychotic and may well be found to be traceable right back into very early childhood, if not to the first months of infancy.

Supposing it is true that the reactions of the cyclic and schizoid personalities are due to emotional traumata received in the first six months of life, it is very doubtful if the patient can be led back intellectually to this era of his existence, if only because his brain tracts are not at that age sufficiently myelinated, to allow of the permanent recording of events. He must, therefore, merely accept the suggestions of the psychotherapist, that this or that happened at this early age. If this suggestion is accepted with sufficiently great emotional intensity to bring to the patient an absolute conviction, then this may be as good as a reasoned intellectual acceptance of the situation. It is probable, however, that this intense conviction as a result of suggestion is seldom achieved, since it is characteristic of psychotics that they always think they are right, and so it would seem likely to be a precarious basis of cure.

Apart from all this, Devine was in the habit of describing schizophrenia and cyclothymia as biological, rather than psychological deviations, and in this he was almost certainly right. This is another way of saying that these patients are true psychopathic personalities with an inherent factor, which owes nothing to environmental incidents, although, of course, it may be modified by these. This definition also implies that these patients are not likely to be cured by psychological means alone, however much their condition may be ameliorated.

It must also be borne in mind that the process of psychoanalysis may be very disturbing to the patient's mind, especially in the early stages, for example during the period of negative transference. It is unquestionable that on many occasions suicide and other psychological incidents of an undesirable nature have been precipitated in the course of an analysis of patients suffering from psychoses.

The scientific 'satisfaction' of one of the pioneers of analytic treatment may be recalled. He analysed a schizophrenic, who thereupon committed suicide. Being a military patient, a court of enquiry had to be held and the members, being unversed in psychiatry and in the methods of psychoanalysis, failed to appreciate the argument that the suicide proved the success of the analytic treatment, since by means of

the treatment the patient had been brought to face reality, which he had previously avoided by retiring into phantasy. Since he was quite unable to face the situation disclosed by analysis (incest wishes directed toward his mother) he behaved in the only possible logical way and put an end to his life. Others besides the members of this court might fail to be impressed with the success of the treatment !

This, however, is no argument against the continuance of the treatment of these mental illnesses by analytic methods, by sufficiently skilled practioners, at the right stage of the disease and in circumstances, in which any relapse or exacerbation can be properly and promptly dealt with. Such psychoanalysis must, however, be regarded as a research rather than a therapeutic procedure, for such investigation did, and still does, add greatly to our knowledge of morbid psychology and may eventually throw a flood of light on the true genesis of these disabilities about which we know all too little.

It seems very probable, therefore, that in every case there is a psychological factor, though this may not be the only one or even the chief one in the production of the illness, and often this can be dealt with by psychotherapeutic methods to the benefit of the patient. Still all things considered it is probably better to leave the analytical treatment at least of the more advanced psychotics to those working in institutions. The free-lance psychotherapist who does not wish to confine himself to research will find plenty of work ready to his hand, without embarking on this difficult and dangerous field of work.

Apart from the deep analytic treatment of the psychoses, however, there is no question that transference is valuable in keeping the patient on as level a keel as is possible, at least for a time, and only whilst the transference lasts.

The manager of an office asked one of us to see a boy of nineteen, one of his clerks. He had been intelligent and efficient, but lately his work had been falling off and he was becoming hostile and morose, absenting himself from the office on several occasions without reason. He was an early case of schizophrenia, but neither shock nor insulin therapy was then in vogue. He was without friends or relatives, but

a reasonably good transference was obtained and during the next few months he improved considerably, his work reports recorded a return to something like his previous efficiency. Then for no very obvious reason the transference began to fail. As there was no one to take responsibility, certification would have required the intervention of police or relieving officer and quite wrongly this issue was evaded and postponed. One day he blindfolded himself, walked into a tunnel and was killed by an oncoming train. Transference had apparently failed after it had been beneficial for a time; when this happened disaster ensued. Even in this case, however, it must be admitted that the transference may have had no influence whatever on the course of the disease, and that the temporary improvement only coincided with a natural remission, which we know are not uncommon in the course of this disease.

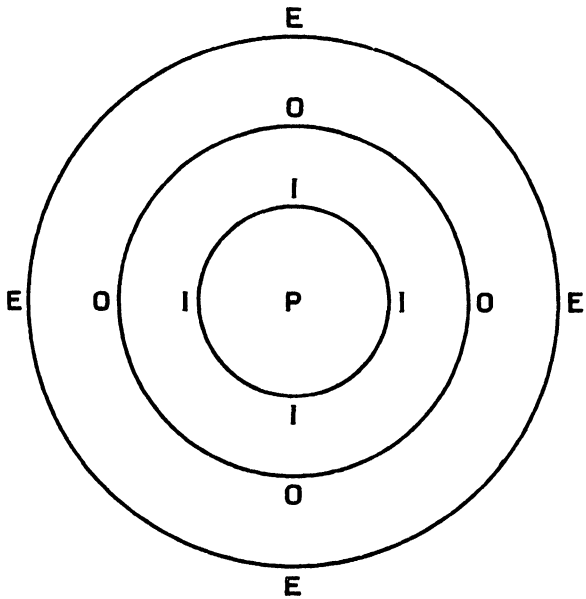
All cases of psychosis require very careful handling and the rehabilitation process of psychotherapy and occupational training must be continued until the patient is really able to face society and the demands of life outside the protecting walls of the mental hospital, or the care of the particular psychotherapist who has succeeded in establishing a satisfactory positive transference. Every experienced psychiatrist knows how, all too frequently, suicide or attempted suicide may occur just before the patient is about to be released from hospital or pronounced recovered, when apparently courage and hope suddenly break down and are replaced by blank despair.

The subject will be discussed in Chapter XIII, but it may be worth mentioning at this place, how dangerous it is to permit unskilled psychotherapists to undertake the treatment of psychotics. This applies even to those who are skilful psychotherapists within their limits, but who lack a wide knowledge of physiology and pathology. These are found among the ranks of lay psychotherapists and even of medical psychologists who have started their specialty without the requisite experience in ordinary clinical medicine. As has been said such treatment is fraught with difficulties and beset by dangers of immediate or remote regression and relapse of the patient. Treatment of the schizophrenic, at any rate, should therefore

never be undertaken lightly and probably only in a mental hospital with the patient still under care, or in circumstances in which all the amenities and safeguards obtainable in such a hospital can be provided at the very shortest notice.

APPENDIX TO CHAPTER IX

Dr. E. R. Matthews has put forward a concept, which, while it may not withstand full philosophic scrutiny, has pragmatic sanction as a graphic objectivation of mental illness and its treatment.



E is the environment, to which the individual is called upon to adjust.
P is the fundamental personality.
O is his outer ring of defences, where he has made a practical adjustment to his environment.
I is his inner ring of defences; a ring of phantasies and wishful thinking of 'as ifs' and 'if onlys'.

The environment and the individual are in a more or less continual state of attack and counter-attack. If *O* is bent, but not broken, then there is reactive anxiety and an alteration of the environment (exhaustion of the attack) or the advance of the individual's own reinforcements to *O* will restore the position.

If *O* is breached and *I* is bent, then a true psychoneurotic anxiety results. Then the defences of *I* must be looked to and the psychotherapist must help to rearrange and fortify the phantasies and wishes of the patient so that the counter-attack, which he, the patient will make, may be well directed and frequently these are successful in restoring the breach in *O*.

If *I*, however, is inherently weak and unrelated to reality, then the successful attack on *O* may carry the ' enemy ' right through *I* and well into *P*. Then we have a ' biological deviation ', which we call a psychosis and psychotherapy can do little to help if the breach in *I* is wide. If, however, the breach is sufficiently narrow, it may be closed, either from within by the *vix medicatrix naturae* or from without by psychotherapy. The patient may thus be able to readjust to the environment.

If *P* is entirely sound, then *I* will be adequate and secure. If *I* is really adequate and secure, then *O* will be a bastion of such strength that no enemy from the environment can break through and the patient will be immune from psychoneuroses.

Inasmuch, however, as the human being at the present stage of his existence and development is never perfectly sound in his *P* everyone is probably subject to psychoneuroses (a break through *O*) and even to psychosis (a break through *I*) if the enemy from the environment finds a weak spot in the defences. What sort of an enemy may find such a weak spot and where such a weak spot may be, neither the subject nor the observer may be able to predict.

It would appear that the extrovert ' lives ' close to and just inside *O*. The introvert ' lives ' close to and just inside *I*. The schizophrenic ' lives ' inside *I* in a state of uneasiness, seriously disturbing *P*, so that if and when *I* is breached he may burst out in a state of catatonic excitement, try to patch up *I* with false phantasies or paranoidal ideas, or retire farther into the depths of *P* in a hebephrenic state. The cyclic seems to ' live ' well inside *P* in his depressed state and right out at *O* in his elated state, but how he changes his station or why this should take place, we do not know.

CHAPTER X

PSYCHOTHERAPY IN THE TREATMENT OF MENTAL DEFICIENCY

So far as persons who come within the legal definition of mental deficiency are concerned, psychotherapy has only a limited place in their management, since few of them have sufficient intelligence to benefit by analytical or persuasive methods. Nevertheless the defective may be, and often is, very suggestible, and this characteristic may profitably be used to guide him in his behaviour and correct any superficial abnormalities of mental adjustment.

Some extremists of the analytic schools have claimed that their methods should be used in the actual treatment of mental defect, but however free the associations of the patient may be, however passive the analyst in the working out of the analysis, it is necessary for the patient to have a modicum of intelligence. Cure in the long run depends on the ability of the patient to understand and appreciate the relative importance of the various factors which underlie his illness. He must be able to follow a logical argument, to appreciate values and to deduce a conclusion, all of which are beyond the power of even a high grade mental defective.

Most authorities in fact agree that the treatment of the mental defective is an educational rather than a medical problem, since the underlying condition is either congenital or present from a very early age and, for this reason, anything like a radical cure is impossible.

Beneficient suggestion may, however, as has been said, be very usefully employed, but this hardly comes within the purview of specialized psychotherapy.

Roughly speaking the mental defective properly so-called, is a person with the mental age of a child of under ten, that is with an intelligence quotient of 70 per cent. or less. It is

usually, though not always, found that such a person cannot successfully take his place in the ordinary struggle for life. Consequently he has to be placed under the care, either of his own relatives at home, or of the state in some sort of institution. There are some institutions which care for defectives at the charge of their relations, but these require to be very well run on a large scale to be a financial success, and their numbers are likely to diminish rather than to increase. If then a person is so lacking in capacity that he cannot ever fend for himself, how far is it worth while to treat him ? Even if something could be done by psychotherapy to smooth out the difficulties of mental defectives as they arise, with so much call on the few who are qualified or personally suited to administer psychotherapy, it would hardly be worth while expending time on them even though they do develop symptoms of psychoneuroses or of psychoses. It is as well to admit that in attempting to treat abnormalities superimposed on the original defect, the simplest forms of suggestion and education are all that should be attempted, together with the establishment of a certain degree of positive transference. If a mental defective likes and trusts a person and that person is prepared to take an interest in him, such a positive transference can readily be established. It is remarkable in these circumstances how tractable and docile a defective may be, and a good ' leader ' will get the very best from him which he has to offer, even though that best is but a poor thing, just as a bad leader may induce the defective to undertake all sorts of asocial behaviour. Such a leader, however, need not be medically qualified.

When however the class just above the legally defined mental defective is considered, the class commonly referred to as ' dull and backward ', then psychotherapy and experience in medical psychology may have very great relevance.

Before considering the part which psychotherapy has to play in dealing with this group, we ought to be quite sure as to what is implied by the terms used. It should be realized that the definition of mental deficiency is a purely arbitrary one, since fending for oneself in the community in which one finds oneself, naturally depends on the standards of that community and these differ considerably. The person who

might require certification in a highly complicated civilization, such as we find in western Europe might get on very well in tropical Africa, or even in India or China. So in any community there are considerable differences in the demands made on different citizens and it is difficult to know where to draw the line. There are many people who will not rise above the level of the hewers of wood and the drawers of water, but we have no right to class them legally as mentally defective, provided there is a demand for such unskilled labour, for they will be able to earn their living without much difficulty. But, if a community arose in which such unskilled labour was performed by mechanical robots, we might have to class the unskilled labourer as a mental defective in law, since he would not be able to earn his living and support himself by his own exertions.

Similarly those who are defective in certain special capacities, although their general intelligence is of a reasonably high level, might find that in a highly specialized community they could find no remunerative place. Actually, however, we need not worry too much about such people at present, as there is still plenty of demand for unskilled labour and there is a sufficient variety of careers open to the adolescent to enable him to choose one in which his general or special weakness will not handicap him too much. It is not impossible to imagine, however, that social conditions might develop in such a way that these things would matter a very great deal and it is remarkable even now, how often people whose abilities are deficient in one particular line, hanker after success in just that line, and are unable or unwilling to admit their limitations and so suffer from severe feelings of frustration.

It is clear that the people with only very moderate intelligence are relatively mentally deficient if not legally so. They will never be able to take advantage of higher education or fill the more responsible callings which require a high grade of general intellectual achievement. For such people some simple psychotherapy will often enable them, or persuade them, to take a more proportionate view of life and of themselves and, at the same time, relieve them of many emotional conflicts and much feeling of frustration. In this way it is possible to free energy for every-day life which has previously

been engaged in unproductive efforts to solve conflicts. Any deep analysis, however, is contra-indicated, for the limitation is inherent and not acquired. Not only will skill in deep analysis, however great, fail to provide what was not there at the beginning, but it is too complicated even to be successful in dispelling the clouds which may befog the minds or distort the behaviour of such patients.

In relation to mental deficiency, however, it is necessary to consider the important group of persons, who are not retarded in their education because of inherent defect, but because of emotional inhibitions and conflicts which prevent them learning. These are often mistaken for and classed as mental defectives or dull and backward, and it is here that medico-psychological knowledge is so essential.

In any child guidance clinic one of the chief tasks of the team is to distinguish the retarded from the true dullard. The latter are those who are really defective and only a little removed from the feeble minded. Since these can never do much, no special time and trouble should be expended on them. The former, however, may be found to possess a normal or even superior capacity to learn, but they do not, or for the time being cannot, employ that capacity.

The various forms of intelligence tests most readily elicit the difference between these two groups. These tests are devised to discover not what the subject has learnt, but what he can learn, and, in the hands of experienced and skilful psychologists, an accurate estimate of the real state of affairs can be obtained. This is one of the chief tasks of the educational psychologist in the child guidance team. When such a retarded child is discovered, then psychotherapy should be employed. This will probably take the form of one or other of the analytical techniques, though it need not necessarily be very elaborate. If the child is young or very retarded, play therapy will probably be the method of choice and should be carried out by a specially trained member of the team. By these means it should be possible to discover the emotional conflicts and inhibitions which are preventing him learning and as a rule, it is not difficult once these are discovered to resolve them and so set the child free to take his rightful place in his class.

Before he can do this, however, he may require special coaching to make up lost ground and this may be the special therapeutic task of the educational psychologist or of a teacher trained in psychological methods.

A careful sifting of all dull and backward children in every school is certainly desirable, to eliminate those in whose case time and trouble is not worth taking, and to discover those for whom psychotherapy is essential to enable them to take advantage of the education offered to them.

Mention has been made of a group of persons, who have defects of a limited rather than a general type. Amongst these are the people who lack, or seem to lack, what has been called the social sense.

In addition to the idiots, imbeciles and feeble-minded persons, the law defines a fourth class, the moral defective. The definition is not a satisfactory one, since it implies general defect and only differentiates the moral defective as one whose behaviour renders him dangerous to himself or others. Since the State, in any case, makes a provision for the care of obstreperous and antisocial mental defectives in special institutions, there seems no need to define a special class of moral defectives, unless the definition is made to cover those who are antisocial but not generally defective.[1]

That definition, however, is no more satisfactory than the other, for the vast majority of those who are not generally defective, but who behave in an antisocial manner, are not inherently amoral. Their behaviour can be explained along quite other lines and in many cases it results from psychoneurotic or psychotic reactions. Many people, however, do believe that there is a small group of delinquents who are inherently amoral without being otherwise defective, and in practice these persons are often described as moral defectives and dealt with accordingly, and as is explained in the footnote this is a procedure within the law. They should be classed as psychopathic personalities but are discussed here because

[1] It may be argued that since the legal definition of mental defect is inability to fend for himself in society, a person who cannot make a satisfactory adjustment should be described as mentally defective, although he is not intellectually retarded, but for most people mental deficiency implies intellectual deficiency.

of the legal definition. How those responsible for administering the law should deal with psychopathic personalities is a subject which urgently requires exploration and decision.

It is obvious from what has been said, that this group of personalities presenting problems in morality, like the dull and backward, needs very careful sifting, since some are really suffering from emotional disabilities and are, therefore, eminently suitable for treatment by psychotherapy, which is successful in a large number of such cases. It is none the less true that some of these delinquents though not intellectually defective, are very resistant to psychotherapy and their behaviour does not show any connection with previous emotional episodes.

Two examples of delinquent children, who, though not intellectually defective were falling behind in school, may be given to illustrate the difference between what may be described as acquired and inherent retardation and delinquency. Both were girls aged about fifteen when seen. Both had gained scholarships to a secondary school and so no question of inherent deficiency from the intellectual standpoint could be raised.

The first was the eldest child of poor parents who had worked hard to bring up their family. When the eldest had won her scholarship, they took the attitude that she was now set fair for success in life and could be left to get on by her own exertions, while they turned their attention to the other children.

For the first year at the secondary school she did well, was bright and reasonably popular with the other children and well thought of by her teachers. Then she began to lose enthusiasm, fall behind in her lessons, decrease in popularity and was finally caught taking money from the pockets of the other girls in the changing room. This discovery was made after several small sums had been missed both by children and mistresses.

She could or would not give any reason for the thefts, she hoarded the money and did not spend it on anything for herself or others. In spite of the rather straitened means of her parents, she was not kept unduly short of pocket money, for they were just, if nothing else ; she herself had no expensive

tastes which she could not gratify within reason, so the thefts, which were almost certain to be discovered sooner or later, seemed quite pointless.

Analysis was resorted to from her dreams, and associations from these dreams, and to cut a long story short, it was found that she had dimly begun to think that her parents were no longer interested in her career, and had withdrawn their love for her in favour of the younger children, an opinion which was not entirely untrue.

For this child, the love and approbation of her parents was much more important to her than that of her friends or mistresses, or of her own ambitions toward a successful career as a teacher which was supposed to be her destiny. She therefore began to lose interest in her work, and took no trouble to learn her lessons or to do her home work, and indeed spent most of her time in just being unhappy without much idea of any reason for such unhappiness.

At the time the papers were full of the kidnapping of the Lindberg baby in America and her dreams and associations showed that the following ' argument ' had been going on in her mind below the level of consciousness, ' suppose I was kidnapped, there would be no one to pay my ransom and rescue me ; my parents don't care, they have the younger children and wouldn't think me worth bothering about ; my schoolfellows no longer like me and wouldn't stir a finger to help me and the mistresses have other things to think about as I am no longer likely to be a credit to them. I couldn't bear to be confined in a dirty cave or prison, so I must collect my own ransom and be ready to buy my way out.'

All this took a long time to elicit and critics may doubt the true significance of the phantasy, which was brought to light by the analysis of this child's dreams and her associations from them. However, whether this was the true explanation or not of the change in her behaviour which culminated in her stealing, when she came to full realization of the situation and the parents were persuaded to show more interest in her and to demonstrate practically that she had not lost their love, the stealing immediately stopped, her whole demeanour changed and she soon became the happy popular child she had been before. She did well in her final years at school and

went on to a successful career eventually qualifying as a nurse and being promoted to the rank of sister at a very early age.

The second case was the only child of doting parents, whose only fault was that they were too ambitious for their child and tended to press her forward too much. She also began well enough, but then lost interest in her work and took to stealing money, which unlike the first girl, she spent on sweets, trinkets and other things for herself.

An attempt at psychotherapy failed; she presented no dreams and no relevant associations. On the other hand, if not actively co-operative she was by no means hostile, at any rate at first. But all attempts at treatment led to no explanation of her behaviour or improvement in her conduct. She was equally impervious to punishment of all sorts as to persuasions, appeals to her better nature or to her duty or affection for her parents. She seemed to lack all social sense or regard for other people. All she cared about was to satisfy her immediate requirements and this she was able to do most easily by stealing anything upon which she could lay her hands. Her egocentricity and delight in the limelight suggested an epileptic personality, but not only was there no personal or family history of convulsive seizures, but her behaviour was in no sense explosive or even episodal. Unfortunately at that time the corroborative evidence of the electroencephalograph was not available.

Things went from bad to worse and, finding that her behaviour did not get her all she wanted, she finally attempted suicide by swallowing 100 tablets of aspirin, which, however, only had the result of making her exceedingly sick. Soon after this she had to be put under certificate as the only way to protect her against herself and to prevent her preying upon society.

Certainly in this case there seemed to be something inherently wrong and environmental factors were of no special significance, while in the first case the soil was perfectly satisfactory and it was only the accidental weeds of circumstance which choked the normal growth. When they were removed all went well.

To sum up the relations of psychotherapy to mental

deficiency. In the case of those who are truly and inherently defective, even if this defect is no more than dullness, psychotherapy, except in the form of the simplest suggestions and encouragement to do the best possible within a limited scope, is not worth while and is in most cases useless. Especially is this so when we consider the large numbers calling for treatment and the small number of psychotherapists competent to carry it out.

In the services during the war, the failure of the mental defective to adjust to his new circumstances obstruded itself to a marked extent. The difficulty was met either by discharging these simple dullards to civil life where they could find uncomplicated and routine occupations without any great difficulty in the national crisis of man power, or by drafting them into special non-combatant units, where they could find similar simple occupations while still in the service of the crown.

The latter procedures were on the whole most satisfactory, and it would be advantageous to make some similar provision in peace-time, so that these persons may be provided for and prevented from getting into difficulties on their own account or making difficulties for other people. There seems no reason why this should involve compulsions or legal certification, as organized non-skilled work groups could be formed, into which these people could easily be persuaded to enroll.

Both in the ranks of the dull and backward and in those of the delinquents and so called ' moral defectives ', however, a number of persons will be found who are not defective, but who are emotionally inhibited and in whose case psychotherapy is urgently called for.

Of course in the case of the mentally defective, occupation is essential, as it is in all ranks of the community, but in finding occupation for these people, considerable discrimination must be used if tasks are to be provided suitable for their capacity, and this calls for much psychological acumen.

CHAPTER XI

PSYCHOTHERAPY IN THE TREATMENT OF PSYCHOPATHIC PERSONALITIES

THE term psychopathic personality is one which does not have the precise meaning which is desirable. Henderson (1939)[1] and others have recently done something to crystallize our conceptions, but even now there is no unanimity of definition, and some authors will include one group of patients under this heading and exclude a second which is readily accepted by others.

If the term is to serve any useful purpose at all, some definition, so far as possible in precise terms, is necessary. The following is offered for purposes of discussion in this book :

> A psychopathic personality is one whose behaviour and/or emotional responses are abnormal, as judged by the commonly accepted standards of the community in which he lives ; whose abnormal behaviour is significantly, though not necessarily entirely, determined by inherent bodily or mental characteristics, which differentiate him from his fellows, rather than by acquired factors, whether resulting from trauma, disease or emotional conflict.

Campbell (1946)[2] has advanced the following evidence for the organic etiology of psychopathic personality :

1. Early development of symptoms.
2. Homogenous nature of psychopathic personality as a type ; not mixed with other personality types.
3. Consistent and hopeless repetition of same behaviour in same patient.

[1] Henderson, D. K. 1939. *Psychopathic States*. London.
[2] Campbell, J. D. 1946. *Everyday Psychiatry*, p. 73. Philadelphia.

4. Hopelessness of conventional form of psychotherapy.
5. Constant deficiency of other factors besides conscience, as emotional dulling and sexual deviations.
6. Behaviour of encephalitics simulating psychopathic personality.
7. Post-traumatic behaviour problems simulating psychopathic personality.
8. Poor tolerance to alcohol in psychopaths.
9. Electroencephalographic evidence.

The epileptic exemplifies this definition of a psychopathic personality. His behaviour, quite apart from his convulsive seizures, is apt to be abnormal. It takes the form of egocentricity, exhibitionism and lack of any warmth of affection, together with a tendency to explosive behaviour, but until quite recently, although many observers were convinced that there must be some difference in inherent characteristics between the epileptic and his fellows, nothing definite had been discovered.

Then Lennox and his collaborators in Boston and other workers in this country discovered that epileptics show abnormalities in the rhythmic waves of electro-potential variations coming from the cerebral cortex (Berger's rhythm). Not only were these abnormal waves found to be present in patients suffering from frank epilepsy, but also in their collaterals and other blood relations. This strongly suggests that in epilepsy we have to deal with a familial abnormality, the nature of whose genetic transmission may be discovered before long.

This abnormality is called by Lennox 'constitutional cerebral dysrhythmia'. Such dysrhythmia implies an abnormality in the synergic function of the cortical cells, but what exactly determines this lack of harmony in the working of these cells is not yet understood.

The epileptic then may be taken as a true psychopathic personality, but it cannot be sufficiently stressed that not everyone who has convulsive seizures is an epileptic, in the sense that he suffers from constitutional cerebral dysrhythmia, nor does every sufferer from this dysrhythmia exhibit convulsive seizures. Nevertheless the dysrhythmic will tend to

behave in the way in which we have come to regard as typical of the epileptic personality. Such behaviour indeed is commonly found in those patients who suffer from convulsive seizures, which, so far as we can tell, are not due to disease or injury.

Long before the discovery of this cerebral dysrhythmia, it had been the opinion of many neurologists and psychiatrists that epileptic personalities can readily be recognized. As has been said, they are explosive, energetic egocentric individuals. They are capable of very considerable drive, but this drive is exerted on a narrow front which is directed in such a way as to serve their own advantage. They are incapable of deep affection for anyone and are prepared to throw over their best friends if for the time being it seems to them advantageous to do so. They are exhibitionistic, seeking always to show themselves in the centre of the picture. They are subject to sudden outbursts of anger, disproportionate to the stimulus, and this may be followed by much wilder behaviour than any considered or placid judgment would warrant.

For example, a young man of poor mentality, whose leg had been amputated at the hip for tubercular disease, kept a small sweet shop with his young wife who was in fact really in charge. So far as neighbours could testify, they were a happy couple and the husband was said to be devoted to his wife and grateful to her for her care of him and indeed for providing, to all intents and purposes, for the livelihood of them both. Nevertheless, one Sunday morning he got up at about 6.30 a.m., went downstairs, lit the stove, made some tea, as he frequently did to bring up to his wife and then brutally murdered her with a wood chopper, which he picked up on his way upstairs. His only living relative was an aunt who knew little about him, and it was impossible to establish that he had ever had any convulsive seizures. However, a history of certain explosive episodes was elicited and it was possible to persuade a jury that he was an epileptic (psychopathic personality) and a verdict of guilty but insane was returned. This case came up for judgment long before electroencephalography was available, but it is reasonably certain on the analogy of similar cases that abnormal waves—the so-called delta waves—would have been found.

It is not suggested for a moment that psychotherapy should not ever be used for such cases, in fact the therapeutic test is almost always needed to establish a diagnosis. Indeed even in true epileptics psychotherapy is capable of doing a great deal of good, for in any epileptic episode there is always a precipitating factor as well as a predisposing factor. If this precipitating factor is constantly the same, and, as it often is, psychological in nature, it may well be removable by psychotherapy. In all cases of ' epilepsy ', however, it is just as well to obtain an electroencephalogram, and if abnormal delta waves are discovered indicating a strong inherent factor we ought seriously to consider how long treatment should be continued and how much time should be spent on this particular patient, perhaps to the detriment of others, on whom effort could be more profitably expended. In any case any deep and prolonged analysis aimed at changing the personality of the patient is unlikely to be profitable. Pierce Clark's contention that the epileptic personality owes its characteristics to early psychic traumata and that the fits themselves are physically determined has not been upheld and is unlikely to be true in view of Lennox's work.

On the other hand epileptic manifestations are by no means unrelated to the manifestations of hysteria and in a series of fits there is very little doubt that some of them are hysterical. As Hurst has said, what more powerful suggestion could be presented to an epileptic, than a personal experience of an actual epileptic fit ? It is therefore not surprising that an epileptic should develop additional fits of a hysterical nature if the behaviour characteristic of a fit is suggested to him, especially if by reason of his fit he gains some conscious or unconscious advantage. Since symptoms induced by suggestion can frequently be removed by counter suggestion, psychotherapy may often be very successful in reducing the number and frequency of epileptic manifestations whether these be fits or equivalents.

In many cases the difference between the hysterical and the so called ' organic ' fit is that the trigger which sets off the convulsive attack is located at a higher level in the personality in the psychogenic case, than in that in which the fit is determined by physical causes. This implies in fact that the

trigger area may be under the control if not of volition, then of subconscious levels which can be reached by psychotherapy.

The existence of such high level trigger areas is no doubt determined in many cases by nothing more elaborate than the sense of insecurity engendered in the patient's own mind, or transmitted to him from the minds of his friends, by the actual occurrence of fits. In other cases, however, we may find a long series of causes of insecurity which culminate in the complete abandonment of co-ordinated activity which characterizes the hysterical fit. These require more elaborate psychotherapy for their removal. To consider the more simple cases, however, an epileptic fit is after all an extremely alarming experience to the layman. Yet, except very rarely in status epilepticus, people do not die in an epileptic fit. If epileptics and their relatives could be convinced of this and every one concerned could be rid of the alarm and despondency and the natural consternation caused by the fit, much of the feeling of insecurity would be abolished. It should be explained, of course, that epileptics do run certain dangers and therefore they are debarred from certain occupations which make them liable to serious injury if they do have an unexpected fit. Apart from this, however, there is no reason why they should not live relatively normal lives and engage in some occupation. If this can be impressed upon people and acted upon, a great deal of anxiety will be lifted from all those concerned. Moreover, it is just as important to list occupations which an epileptic can follow, as to enumerate those from which he is debarred.

Generally speaking we must do everything we can to make epileptics happy and this will include relieving them of unnecessary anxiety, which may involve the use of psychotherapy. Apart from this they do require to be occupied and to feel that they are achieving something which will satisfy their egocentricity. Sympathy and friendship are undoubtedly very beneficial to the epileptic, but this may involve a hard task for his would-be benefactor. It must be remembered that because of his peculiar personality, he will not be appreciative of what is done for him and he will tend to exploit his friends for his own advantage. Therefore gratitude and return of affection should not be expected to any extent.

It has been suggested that the epileptic is a person to whom voluntary sterilization might be peculiarly applicable, so that he could enjoy the relief and comfort of marriage without the hazard of transmitting his disability. It should be realized, however, that the epileptic with his egocentricity and tendency to violence is not a good candidate for matrimony and the standpoint of his partner should be carefully considered before recommending marriage, even if the procreation of children were to be made impossible by the legalization of sterilization.

Apart from and in addition to the treatment of epileptics or more particularly of those exhibiting the epileptic personality, by the simpler forms of psychotherapy, it is obvious that the possible utility of the exhibition of pharmaceutical remedies such as epanutin, luminal tridione, etc., should be carefully considered, even in those patients who do not suffer from convulsive seizures. Such drugs raise the threshold of convulsive reaction and it may be that in all cases of constitutional cerebral dysrhythmia they might curb the outburst of behaviour disorder. This is a question which urgently requires further investigation, and there would seem to be ample opportunity for this, since quite a high proportion of children who suffer from conduct disorder are found to show cerebral dysrhythmia. Lindsley and Cutts (1940)[1] give the figure as nearly 80 per cent., while Williams (1941)[2] found 26 per cent. positive in 148 mixed psychoneurotics and Hill and Watterson (1942)[3] found 48 per cent. in 151 psychopaths, although the definition of psychopaths used by them is not quite the same as that of psychopathic personalities adopted here. Obviously a combination of drug treatment with the simpler forms of psychotherapy is likely to produce the best results.

The schizophrenic and cyclic groups of psychotics are true psychopathic personalities, but as a rule these patients are discussed amongst the psychoses and for convenience sake that course has been adopted here.

[1] Lindsley, D. B., and Cutts, K. K. 1940. *Arch. Neurol. Psychiat.* liv., p. 1199.

[2] Williams, D. 1941. *J. Neurol. Psychiat.*, iv., p. 13.

[3] Hill, D., and Watterson, D. 1942. *J. Neurol. Psychiat.*, v., p. 47.

Alcoholism and drug addiction referred to from rather a different standpoint in Chapter VIII do merit discussion in this chapter. It is doubtful whether the sufferers from these conditions can all be properly described as psychopathic personalities. True many are cyclics, especially the dipsomaniacs, who intermittently have bouts of drinking, remaining perfectly sober and even teetotal in the intervals. These people seek relief from the worst miseries of their depressive phase in the narcotic effects of alcohol. Again the schizophrenic may find in the use of the drugs of addiction a further intensification of the satisfaction which he obtains from his phantasies.

Some subjects of drug addiction are apparently simple anxiety cases who have been persuaded to take alcohol or drugs, or, having done so, weakly following the example of others, found some relief from their anxiety and continued their indulgence as a habit which they have been unable to break. Yet those who have to do with such patients frequently state that they do not find them quite the same as the ordinary anxiety case and that ' weakness of will ' is hardly a sufficient explanation of their habit formation. That alcohol is a crutch which may at first seem a good one to the moral cripple, is undoubtedly true, however much the crutch may let him down later. But why did he need that crutch ?

This raises a question which is very difficult to answer. If it is assumed that the alcoholic and drug addict are somewhat different from other psychoneurotics and psychotics, is this difference due to something inherent, that is to say, was it there before ever the patient took to his drugs, or is the difference the result of the poisoning of the patient's brain by the alcohol, morphine or cocaine ? Much more work is required to settle this question, but there is already an impression that there is some inherent factor at work.

In almost all of these cases psychotherapy should be given at least a therapeutic trial. The only exceptions are those who are in such an acute stage of their disability, that they are incapable of co-operating in treatment, or those whose brains are so poisoned by the drugs which have been taken, that their mental condition has deteriorated to a condition of dementia, which is beyond recovery.

The average case, however, requires rehabilitation in the widest sense of the term—mental, moral and physical. Psychotherapy *per se* may therefore not be enough, important though it is in disclosing the real basis of the craving and removing the obstacles and difficulties which prevent a satisfactory adjustment to life. The value of drugs is much less certain than was at one time supposed and the various specific cures have on the whole proved disappointing, except in circumstances in which, whether because of the surroundings of the patient or the personality of the person administering the treatment, psychological or physical agencies have really played a greater part than that attributed to the vaunted pharmaceutical preparations. On the other hand, hypnotics to overcome the insomnia, which in so many cases becomes an inveterate habit, have a very definite and important place in treatment.

Physical improvement is essential, but this should be gained by occupation or competitive games if the patient is able and willing to join in these. The main object of treatment must be to restore the patient's self-respect and his reliance on his own powers of self-management and control. Therefore, anything which will induce him really to believe that he is good at something, will always be the best form of treatment. Some of these patients are bombastic and complacent, but this is only a shoddy psychological façade, erected to guard them in some measure from the storm of their own self-depreciation, and the experienced psychotherapist has no difficulty in detecting its true meaning.

On the whole, therefore, deep and prolonged analysis will not be called for in the treatment of this group, and, in view of the supposedly significant inherent factor, may well be a waste of time. Nevertheless in a few selected cases this long and deep analytical treatment may be very successful and is probably useful also in the present state of our ignorance of the subject, in elucidating the mechanisms which underlie these addictions, even though this elucidation has little therapeutic effect. As a rule, shorter analytic methods, combined with carefully chosen occupation and selected drugs employed as symptomatic remedies as mentioned above, are the methods of choice. Certain techniques of suggestion,

hypnosis and persuasion, which have to some extent been neglected recently, are often useful in the treatment of these cases, and they had a considerable vogue at one time. The various methods of analysis as practised by the modern psychotherapist have doubtless proved more spectacular and often much more successful in the treatment of psychoneurotics in whose case the main causal factors are within reach of such analysis, but if the causal factors are mainly inherent, analysis cannot be expected to enjoy the same measure of success, and the older methods may be well worth a trial, to alter at least the patient's superficial attitude to life.

Inversion. The homosexuals comprise another group of patients which include a wide variety of types and whose disabilities depend on many factors. It is a common-place that every man has a certain amount of feminity in his make-up, and that similarly every woman has a proportion of masculinity. These proportions vary in different individuals, and probably depend to some extent at any rate on small collections of sexual cells properly belonging to the opposite sex, which are present in the body.

The extremely effeminate man who is homosexual (usually passive) and the very masculine homosexual woman (usually active) are familiar and are for the most part problems in endocrinology and have been dealt with in Chapter VII. It should be noted, however, that not all individuals of this physical habit are homosexuals, indeed they may be very vigorously heterosexual. This indicates that the subject is one of considerable complexity, as to which our knowledge is all too incomplete. A certain group of homosexuals then should be classed as psychopathic personalities, and these will not be helped to any great extent by psychotherapy, except in so far as it allows them to have a clear insight into the nature of their disability, its true ethical significance (often grossly distorted, both by the patient and the public) and its implications in relation to society. Such people have a hard task in achieving any sort of satisfactory adjustment and the sympathetic psychotherapist who can approach their troubles without prejudice and without being shocked at their abnormal inclinations, is often of the greatest help to them.

There is, however, another group of homosexuals so-called, whose treatment by psychotherapy is eminently satisfactory, and who should not be classed as psychopathic personalities at all.

In normal sexual development, three stages are passed through. The first at or about puberty, when the sexual urge is represented by an inward tension demanding relief. Such tension at this stage is adequately relieved by nocturnal emissions and by masturbation. So long as it is not excessive and does not become a dominant habit, this latter practice need not be and indeed should not be regarded as abnormal at this stage of life. It is only when, for some reason it is prolonged into the later stages of sexual development, or still worse, when no further development beyond this autoerotic masturbatory stage takes place at all, that abnormality need be considered and serious psychotherapy undertaken. Such, however, is the ignorance and mistaken morality of parents and teachers in respect of this subject of masturbation, that great anxiety and feeling of guilt may be produced in the child's mind. This anxiety—not the masturbation—very frequently requires psychotherapy.

The next stage is an undifferentiated objectivation, when the urge is directed to other persons than the individual himself. Such persons may be of the opposite sex or of the same sex. At this stage which begins just after puberty as a rule, no definite differentiation of the objects of attraction as between one sex or the other has taken place. Since at this age the adolescent frequently finds himself segregated with his own sex, especially if he is at a boarding school, the attraction is often felt towards a member of the same sex. In the majority of cases the attachment at this stage, whether it be homosexual or heterosexual is emotional only, and is no more than the schoolboy or schoolgirl ' crush '. Sometimes, however, physical attraction may develop more or less accidentally or by example. Such attractions whether physical or not may be between persons of similar age, or adolescents may develop an exaggerated and highly emotional ' passion ' for an adult. The older of the pair then has a considerable responsibility as to how the affair develops. It is obviously undesirable that such attachments should develop along physical lines, but it is

almost as harmful if it is ' only ' emotional and is mismanaged. The adult may be considerably flattered by the devotion of an attractive youngster and encourage the continuance of the situation in order to maintain his own self-esteem. When the adolescent later discovers that his devotion is not really returned in the way he thought, his sensitive and poorly integrated sentiments may receive a serious psychic trauma. If on the other hand the adult is shocked and repelled by what he regards as the abnormal regard of the adolescent, he may instil into the latter a sense of guilt from which he may, only with difficulty, be freed. In both cases psychotherapy may be very necessary to treat, not the so-called homosexuality, but the anxiety and depression caused by the failure on the part of the adult to handle the situation with the sympathy, understanding and wisdom which are required.

The next normal stage of sexual development is progression to heterosexual attachments which should ultimately lead to mating and marriage. Too often, however, the taboos, fears and anxieties over sex, perhaps normally felt to some extent by the adolescent (Goethe's ' durch und drang '), are enormously intensified by the prurient and pusillanimous attitude of his elders. These fears and doubts will tend to inhibit the normal progression from the second to the third stage and the child may feel ' safer ' if he retains his affection for a member of his own sex, whom he thinks he understands better, and whom he hopes understands him better. Although the masculine gender has been used in this discussion, this type of inhibition is undoubtedly commoner in girls than in boys.

A similar inhibition may also be caused by too great demands or dominance by the parents, so that the child is afraid to grow up and prefers to remain in the shelter of his early attachments, which in this case is usually for an older person who is an additional father or mother substitute as the case may be.

If these ' undifferentiated ' and undeveloped attachments are homosexual as is often the case, this homosexuality will persist into adult life, until it is either overthrown by a very strong heterosexual urge which is no doubt a common solution, or it is resolved by psychotherapy.

In such cases glandular therapy is emphatically not called for. It may in fact do a great deal more harm than good, for it implies to the patient and his friends a condition of much more serious import and with much deeper roots than is in fact the case. Moreover it heads the patient off from psychotherapy which is the only treatment which will do him any good. Such homosexuality is not fundamental and as a rule comparatively simple explanation and encouragement is all that is required, and indeed too deep probing of the psyche of the sensitive adolescent may be positively harmful.

The homosexuality of later life, due to deprivation of normal sexual outlet under strong sexual urge, such as occurs in prisons, amongst sailors on long voyages, and sometimes among women with no opportunity of normal contact with men, is not really a psychotherapeutic problem. It is practically always 'cured' by a return to more normal social conditions and opportunities. Again, however, the supposed stigma of abnormality may produce secondary anxiety, which may require psychological treatment.

Perversions. If inversion is a complex problem whose genesis is imperfectly understood, the perversions are still more difficult. There is no reason to suppose that they owe anything to glandular abnormality and Freud's theory that they represent a failure of development from, or a regression to, the 'polymorphous perverse' stage of early sexuality is as plausible a theory as any other, although it is by no means universally accepted. Sadism, masochism, exhibitionism or identification with the opposite sex are by no means wholly absent from perfectly normal sexual experience, especially in phantasy, and they ought only come to be described as perversions when they dominate or replace the normal sexual urge. Psychoanalysts claim successes with prolonged and deep analysis of patients exhibiting perversions and all psychotherapists have probably treated some cases successfully. Too often, however, perverts are very resistant to treatment and for this reason it may be considered that there is some inherent factor, the nature of which has not yet been discovered, which distorts normal sexual growth. These patients therefore are true psychopathic personalities, since they owe their condition to something more than a

regression to what is regarded as a normal stage in human development.

It is perhaps important to insist that a patient should not be regarded as a pervert, unless his perversion is persistent and replaces normal sexual desire so that he can only achieve full sexual satisfaction by means of that perversion. As has been said, transient impulses towards sadism and the rest, which are probably never converted into action, are normal enough. Nevertheless plenty of patients develop anxieties, depressions, feelings of guilt and other psychoneurotic symptoms as a result of these phantasies and transient impulses, just as does the masturbator, and these symptoms, though not true perversions, may require psychotherapy for their relief, even if this only takes the form of reassurance and education as to the meaning and true significance of these freaks of the imagination.

The Psychasthenic. There is a class of patient which was admirably described by Janet under this term, who is consistently and persistently assailed by the '*folie de doute*'. Such a patient may spend long hours making up his mind which sock he should put on first, and he is quite incapable of forming these habits which James so well described as the flywheels of society. These patients are certainly allied to the obsessionals and Janet classed them with this group and described all such patients as being lacking in ' psychological synthesis '. As a descriptive term this may be admirable as implying a laxity of normal associational bonds, but it cannot readily be translated into terms of physiology.

Some ardent psychoanalysts have claimed that these psychasthenics are in fact only severe obsessionals and that they can be cured by prolonged deep analysis. Most psychotherapists, however, find them beyond their therapeutic competence so far as cure is concerned and perforce have to accept the dictum of Janet that they are not curable, but require a director who is prepared to make up their minds for them throughout their lives. It certainly is advisable that the busy doctor should not be selected as the director, otherwise the time he might usefully devote to the effective treatment of curable patients may be seriously curtailed. The parson or even the lawyer may have to, or be persuaded to, assume the

role of director to a psychasthenic, but he will certainly regret it !

It is almost certain that some inherent factor is significant in the genesis of this condition, but whether this is some special form of defect or other abnormality of mind as to whose nature we are completely ignorant, has still to be determined. In any case psychotherapy would appear to have a very limited use, except in so far as the director assumes a didactic role. It is doubtful if even the deepest and most prolonged analysis serves any useful purpose and so in these cases such treatment should be regarded as a waste of time.

There are some people who would maintain that all psychoneurotics are psychopathic personalities; in other words that they are born and not made. This has been dealt with in more detail in Chapter III under the heading of 'Temperamental Instability'. Most modern psychologists would maintain that perfectly normal people with no discoverable inherent defect, and who have never shown any previous sign of ill-health either mental or physical can in certain circumstances develop quite typical psychoneuroses. It is held too that in more prolonged cases of psychoneurotic illness, while an inherent factor may be present it is not of serious significance. It is probably true that in psychoneuroses the environmental factor is by far the most important, nevertheless there can be no doubt that some inherent factor is present in varying degree in almost all psychoneurotic patients. Indeed, we may go further and state that there is no human being who is so constituted that he can make a perfect adjustment to all possible circumstances in life.

The psychopathic delinquent has already been dealt with in Chapter X and need not be further discussed, although he is probably more properly described as a psychopathic personality than as a mental defective.

It will be seen from this somewhat inadequate discussion of the psychopathic personality, that psychotherapy has a place and an important place in the treatment of these patients, but it has its limitations, which in all honesty we should recognize. If we do not, we run the risk of expending a great deal of unprofitable time and labour, which we can ill afford.

CHAPTER XII

THE PATIENT'S REACTION TO BODILY DISEASE

THOUGH the teaching of psychological medicine is gradually coming to take its rightful place in the Medical Curriculum, the psychological aspect of somatic disease and disability, in particular the reaction to serious illness, quite apart from psychosomatic conditions, visceral neuroses and the like, receives little attention.

This is partly due to the segregation of cases so that almost automatically a patient is considered to be suffering either from bodily or from mental disease but not from both. If his illness is deemed to be physical any mental effects are not thought to be relevant and anyway it is supposed that the psychological aspect of illness is covered by the teaching of general psychological medicine. It is true that reactive anxiety receives attention from psychiatrists, but the particular form of anxiety we are discussing does not receive the stress it deserves.

The right place to teach this branch of medicine is undoubtedly in the medical wards and not in the lecture room ; only so can the student form the habit of mind which helps him to see the patient as a very human individual, perhaps not a little frightened, anxious or depressed, and not only a vehicle of interesting physical signs. There is no doubt that there is a danger at the present time of regarding psychological medicine as a definite specialism and so the province of the specialist only, whereas it is true to say that both in prevention and treatment the general practitioner has by far the most to do with it, and every medical practitioner, in whatever field he practises, should consider the mental attitude of the patient. The personal attendant of the patient is the only individual in a position to relieve the mental suffering associated with serious illness, and it is his wise handling

that will prevent a temporary illness from forming the basis of subsequent psychoneurosis or even hypochondriasis. The family doctor, moreover, is in the best position to estimate the effects on the patient of the attitude of relatives and friends and to enlist their help if possible, or to remove the patient from their influence if he considers it advisable.

Under present conditions of work, however, a general practitioner or houseman has little enough time to do more than diagnose an illness and prescribe medicine, but it is to be hoped that in the near future this state of affairs will be improved and he will be able to devote more time to each individual patient. With improvement in the social services he will be in a better position to bring organized relief to the patient, to provide assistance for instance to a sick woman in the management of her home, or relieve the breadwinner of the financial anxieties associated with a long illness. Only a doctor in intimate contact with a family can realize what it would mean to the peace of mind of a patient to know that provision for himself and his family was assured; such security is a necessary foundation for success in the treatment of many long-term diseases such as tuberculosis in which rest of both body and mind is essential for cure.

There are many factors concerned in the psychological adjustment of a patient to his illness; his religion and his whole outlook on life, effect and are effected by it.

The amount of help that a patient obtains from his religion is a very individual matter; for some it is a complete answer to the problem of sickness and death, but such people are exceptional. It must be admitted that for many people, if and when they have lost the idea of a personal God who is interested in them as individuals, the cornerstone of help in time of trouble has been lost; a support, moreover, which they have not been able to replace by any philosophy of living. On the other hand there are some cases in which a blind faith in an all-loving Deity prevents a patient seeking medical aid until disease has gone beyond all hope of cure. An adequate philosophy of life is of the greatest value to any patient, but few doctors are competent to supply this.

R. L. Stevenson has said that true good health is to be able to do without it, and it is the duty of the doctor to do his

share in helping a patient toward the attainment of this ideal security of mind. How nearly he will succeed will, however, depend to a very great extent on general factors beyond his control; the educational background of the patient and his scale of values are of great importance and the question of his social and economic position has also a bearing on the case.

For many people the art of living has become a fight for mere existence, and even where there is no social insecurity, specialization at an early age, both in vocational training and in the enjoyment of leisure, causes a very serious handicap when illness or increasing years renders impossible the following of the few pursuits in which he is interested. It is true to say that the lives of many people rest on the tripod of the family, the business of earning a living, and one particular sport or outside interest; some indeed are supported by the first two only, and the lives of many women rest solely on the family. It is easy to see how instable such lives are likely to be when temporary or more permanent disability remove first one prop then another; there is little wonder that life appears empty and the patient comes more and more to live in the past or seeks the solace of alcohol to give a fictitious colour to a life grown ' stale, flat and unprofitable '.

Provision against insolvency of this sort is in the hands of the educationist and can only be provided during the formative years when general cultural interests in music, art, literature and the natural sciences can be made to form a firm basis for living even under adverse conditions.

Apart from such general considerations, the physician has it in his power to render considerable help in individual cases both in the prevention and treatment of serious mental complications of bodily ailments.

Adler has suggested that in childhood, compensation for organ inferiority can be fostered and that over-compensation can be diverted into useful channels instead of warping the personality and leading to pathological aggression or the various manifestations of despair. To this end those who have charge of the child, sick or disabled, in his early years, must avoid any show of depreciation and must stress the positive elements for good in the child's make up. His inferiority

should not be a subject of comment in his hearing and no pessimism for the future should be allowed to hinder his own natural efforts towards adjustment. Literature abounds in characters exemplifying the twisted personality that is so easily formed in association with bodily defect. Shakespeare's Richard III is a typical example, and in every-day life we see how often the man of small stature shows undue aggression both in voice and manner; the weakling turns to deceit or even crime to attain his ends, or disguises his weakness by the various psychoneurotic mechanisms at his disposal, either withdrawing from his fellows or leading a parasitic life in a society on which he feels himself justified in making exorbitant demands. The fact that these unsatisfactory reactions are by no means a necessary corollary to disability, is proof that a proper understanding of the problem could go far to eliminate them.

With regard to temporary illness and disability, unless of a very serious nature, little more is required of the doctor than encouragement and optimism. He should, however, allay the patient's fears and anxieties and see to it that so far as possible the little attentions and comforts which make such a difference to the patient's security are procured for him. In the case of the child there is sometimes difficulty in his return to normal living; quite naturally the child has no wish to leave the centre of the stage which he has enjoyed during his illness, but he soon adjusts himself to community life again if his return to it is made through the medium of reassociation with his friends and the resumption of congenial activities; indeed the necessary readjustment is probably a valuable experience if it is reasonably smooth. Disease requiring surgical treatment in children raises the question of the mental trauma of anaesthetics. This has probably been exaggerated in the case of normal children, but in cases where the child is already timid and especially where parents show that they are afraid, it probably serves still further to convince him of the hostility of the people in his small world. In such cases a pre-anaesthetic drug should be administered, but, even so, the child should be given some intimation that special treatment is pending; to 'steal a march' on a child is always bad policy.

The psychological aspects of the more chronic diseases such as tuberculous bone disease, chronic heart disease, etc., present a more serious and important problem because they demand a complete readjustment in the patient's life. When we consider how often in the present state of our knowledge we have to confess our inability to cure these conditions or restore normal function, it will be realized how important is this side of the physician's work.

Children very quickly adapt themselves to a new life situation if they are treated on the right lines. Anxiety and self-pity do not last long because they do not come from the patient himself. They are usually imposed from without by injudicious remarks at the bedside or still more commonly by the anxious demeanour and grave expression of those around. Young people live much more in the present than do adults and the bogey of the future does not loom so large. Anyone who has worked in an orthopaedic hospital must have been struck by the happiness of these patients, many of them doomed to permanent severe incapacity. It is only after discharge that they are liable to show an unsatisfactory psychological reaction to their physical inferiority and every provision must be made to prevent this by training them for work which they can do.

As the same principles of psychological treatment apply to all these chronic conditions there is no need to describe different types of disease separately. Rheumatism embodies most of the difficulties seen in other diseases and its management will therefore be considered as typical of the others.

It has been said that the most common complication of acute rheumatism is not heart disease, but neurosis. A large proportion of adult patients suffering from cardiac neurosis give a history of rheumatism in childhood and state that suspicion was early cast on the heart, often as the result of the discovery of a murmur or on the basis of probability only. It is not suggested that drawing attention to the heart in childhood is sufficient to cause neurosis, otherwise every patient with a cardiac lesion would be neurotic; it is very largely a matter of the manner in which the question of cardiac involvement is approached both by the doctor and the patient's relatives. Discussions of possible complication should never

be held in the child's presence, and he should be kept at rest until it is clinically certain that there is no cardiac involvement, or, if such is diagnosed, until it is quiescent. Examination of the heart should be made part of a general investigation and undue concentration on it or fussy repetitive examination is to be avoided. If the heart has escaped damage, full activity should be restored as soon as possible without any reservations or injunctions to ' be careful '. In the absence of positive evidence to the contrary the normality of the heart should be assumed.

When the heart is affected it will be necessary to impose limitations and these should be made provisional rather than final. Enquiry should be made about the child's natural interests or inclinations and then any restrictions should be imposed rather by stressing what the child shall be allowed to do rather than what he shall not ; every effort should be made to encourage interests which are likely to be within his capacity. The studious child will naturally fare better than the child whose aspirations are athletic, but even here outdoor pursuits can be found which will compensate him for his inability to enjoy the more strenuous sports. In this way the doctor takes upon himself the responsibility of reorganizing the child's life and reorientating him, not by negative prohibitions, but by a positive outlook.

When the child returns to life amongst his fellows, an effort should be made to ensure that he goes into an environment where he will least feel his physical inferiority. It is satisfactory in this connection that at most schools proficiency in athletics has ceased to be the only criterion of success. Special schools for disabled children are invaluable during prolonged convalescence from cardiac and orthopaedic conditions, and under the new Education Act, such schools will have to be provided by local authorities, but after this stage it is probably better to allow a gradual return to a more normal social life. If, during his illness, he has been sufficiently encouraged to take a positive attitude to the potentialities yet remaining to him, he will not in future years develop undue aggression or shyness, and will not tend to use his disabilities as a lever to free himself from a reasonable proportion of life's responsibilities.

One other aspect of the organic basis of mental symptoms in children must be mentioned. Organic cerebral disease is considered elsewhere, but here we must mention the backward child whose backwardness is due not to any inherent cerebral defect, but to defective vision or partial deafness, or to some mechanical difficulty such as adenoids which interfere with sleeping and general well-being. From such backwardness there may be so many side effects and psychological reactions that the child is first seen because of behaviour difficulties. It is therefore of paramount importance that a complete physical examination should be made of every case before arriving at any conclusion or discussing treatment.

Much that has been said about the psychological treatment of chronic organic disease in children, applies also to adults, and in the case of many such with psychoneurotic trends precisely the same rules apply, but the well-balanced adult patient can be given more personal responsibility in noting his subjective symptoms without risk of producing a hypochondria. This is particularly true of heart diseases where, unlike a child, the adult patient may profitably be told to live within the limit of his subjective sensations.

Rehabilitation should go hand in hand with medical treatment and should indeed be regarded as an important part of it, so that by the time the patient has attained the maximum amount of recovery he will have developed vocational capabilities and recreational interests in keeping with the degree of his incapacity; it is most gratifying to find how quickly he will reorientate himself to an entirely new way of living if given sufficient help and encouragement from those around him. This is particularly well seen in cases of coronary disease where instead of the chronic invalidism so commonly seen, a patient can be returned to a useful life and find happiness in pursuits which he has formerly ignored or even despised.

In the psychological management of pulmonary tuberculosis an added difficulty presents itself. Not only must the patient adjust himself to a long period of inactivity followed by an altered regime of living, but it is necessary during the open infective stage to exclude close family contact, and this is the cause of much distress, particularly when parents must

be separated from children living in the same house. In practice what usually happens is that the restrictions are gradually discarded and this is obviously unsatisfactory. It is to be hoped that in time sanatoria will help to solve the problem, but great changes will have to be made to increase the accommodation and, in many cases, to improve the amenities and standard of treatment available. The provision in them for frequent visiting and some degree of privacy for convalescent patients is absolutely necessary if restlessness and impatience are to be avoided. In no other condition is an understanding of the psychological aspect of disease so important, because an anxious mind has a very real bearing on the patient's resistance to the Tubercle Bacillus, and no amount of scientific collapse therapy can avail against an infection in an individual already distressed by mental conflict or anxiety. Success in treatment depends also on successful discipline, and to achieve this the patient should be informed at the very beginning just what his illness implies, and how far success depends on his co-operation. He should be told that if he follows instructions he can expect to be well in a given time and he should be warned of the disastrous effects of curtailing treatment. The price that he has to pay for health is a heavy one and should not be minimized, and he can be helped enormously by the encouragement of the physician and by the co-operation of his family.

Skin diseases and disfigurement, especially in women, call for special mention because like other conditions which tend to lower self-valuation they call for some mental adjustment. Every effort should be made by the dermatologist and even the plastic surgeon if necessary, to minimize unsightly defects. In such patients it is always necessary to consider how far any observed nervous symptoms may be due solely to the repressed idea of the disfigurement. It is the duty of the physician, after sufficient transference has been obtained, to bring this into consciousness and open discussion, and to urge appropriate local treatment if this is possible. Similarly adolescent acne may add to the difficulties of puberty particularly as it is frequently associated in the lay mind with masturbation, and so may induce a sense of guilt. It therefore merits serious attention even though the patient,

too frequently ashamed of his ' spots ', may not complain specifically of the condition.

Fatal Disease.

The psychological management of incurable disease presents certain problems—when and how much should a patient be told about his condition. Each case requires individual consideration and the experienced physician can help to prevent much needless mental suffering by a proper appreciation of the factors involved. Of course, where there is even a possibility of radical cure there should be no hesitation in placing the full facts before the patient so that he may be in a position to decide for himself on a course of action, but we are here discussing cases where the hope of cure no longer exists.

There are doctors who, acting as they say on moral principles, make a practice of telling the full facts to every patient. This is just as reprehensible as to take the opposite stand in which all the facts are withheld and every patient is deceived. Though there can be no rigid formula certain generalizations may be made.

It is unwise to give a verdict of incurable disease to a patient who is going about and still finding interest and happiness in life. Apart from the fact that unnecessary suffering is thereby caused, an apparently well-founded diagnosis may prove wrong, and a disease which is incurable to-day may not be so in six months' time.

A patient should not be told that his illness will prove fatal unless he asks, and then only if he asks as if he really wished to be told. So often a patient will say, ' But it isn't cancer, is it ? ' or ' but surely you will be able to treat it ? '. Such a patient is not prepared for the truth and a final opinion should be delayed. He should not, however, be deceived and it is never justifiable to adopt a ' pooh-pooh ' attitude. It is not really difficult to allow the question to remain open whilst at the same time indicating that the illness is of a serious nature. This is important because it allows him to make some preliminary mental adjustments before facing the full gravity of his condition, and it will induce him to put his affairs in order so that proper provision is made for his family ;

indeed where there is reason to suppose that this has not been done it may be advisable to discuss the point with him.

It frequently happens, however, that a patient really wants to know the truth, and there should be no hesitation in telling him. Failure to do so is usually a sign of lack of courage on the part of the doctor, however he may rationalize it into thoughtfulness for the victim. Sometimes he withholds the truth at the urgent request of relatives, nevertheless, deception in these circumstances is a breach of faith with the patient, and the doctor should not be a party to it. He must, of course, be very sure of his ground before offering a final opinion. The result of such honesty is almost always satisfactory and the after-treatment of the patient is very much facilitated.

Sometimes, however, a patient realizes the gravity of his situation without wishing to have it put into words and the doctor should show a sympathetic understanding and respect for this wish.

The management of the relatives is sometimes more difficult than that of the patient—either they adopt an unduly bright or optimistic attitude which causes him to be emotionally isolated and therefore fretful and querulous, or they surround him with a gloom which is even more difficult to bear.

So far as possible the doctor should set the tone of the sick room, and it is most gratifying to see the change towards serenity when a harmonious relationship between the patient and his family is established on a basis of sympathetic understanding.

A discussion of the drug treatment of incurable disease is out of place here, except to say that pain must be relieved on psychological as well as physical grounds. In some cases a patient is prejudiced against the use of all drugs, and if so, an effort should be made to relieve pain by other means such as peripheral nerve block or injection of the posterior roots. However, opium derivatives should not be given except for pain because of the mental depression and personality changes which follow the prolonged use of these drugs, and because the patient may develop such a tolerance that they fail in their effect when most needed.

The solace to be found in religion has already been mentioned and further discussion is unnecessary. There is no universal

rule. In some cases it is responsible for an atmosphere of peace and serenity into which the doctor need not trespass except to relieve pain. In others it gives no help, while its attempted ministration in some hands may amount to an intrusion into the patient's privacy.

Eventually the physician's responsibility for the patient's attitude of mind ceases because toxaemia so clouds consciousness that the affairs of this world cease to be of interest and the emotional life loses its potentiality for suffering. Medicine is now out of place, particularly the fussing type designed to prolong for a short time a life which has already lost its meaning and the doctor should limit himself entirely to consideration of the patient's physical comfort, and giving such help and advice as he can to the patient's relations.

Thus psychotherapy has a very broad application in the management of sick people, whatever the source of their illness. It is an important part of the help which a doctor brings to his patients and may indeed be the only help he can give. Psychotherapy of this sort is essentially the province of the general practitioner and not of the specialist and so its importance should be stressed in the present-day teaching of students. Unfortunately such consideration for the patient's peace of mind is all too conspicuously absent from the hospital wards where the student is trained. To learn this art he must be able to penetrate to the patient's home and come into close contact with the relatives and friends. If the future practitioner is required to begin his professional life, as is proposed, as assistant to an experienced and wise family doctor he will learn much of value which the best-equipped and most up-to-date hospital could never teach him.

CHAPTER XIII

THE ORGANIZATION OF PSYCHOTHERAPY

THE previous chapters have shown that, although psychotherapy has its limitations and cannot do quite all that was supposed to be possible in the first flush of enthusiasm, nevertheless its field is a wide one and, with the relaxation of tension after the war, the demand for psychotherapy will be very great indeed, just as it was after the last war.

At that time there was considerable opposition to what many people regarded as a new-fangled fad which, so far as Freudian doctrines were concerned, was held to be nasty and immoral. Now, the whole subject of medical psychology is much more generally accepted and even its most inveterate opponents find themselves unable, at least in public, to dismiss it as unpleasant nonsense. Twenty-five years ago there were only a few doctors who felt themselves sufficiently skilled to offer to treat their sick patients by scientifically-based psychotherapy; now, not only are there many more well-qualified doctors, who rightly consider themselves competent and are so considered by their fellow practitioners and by the public at large, but in addition, many non-medical men and women, parsons, academic psychologists and others consider themselves well fitted to treat the public by psychotherapy. Whether such non-medical psychotherapists are in fact as competent to treat patients as they claim to be, is a matter of considerable controversy at the present time. If they do prove themselves competent, however, at least to work in conjunction with a medical psychologist, their services will prove very valuable, for in all probability the demand for psychotherapy, even having regard for its limitations, will increase rather than diminish.

In the past much time was lost by attempting to treat many patients who were quite unsuitable for any form of

psychotherapy, or at any rate for any elaborate use of this treatment. Truly dull people, psychopathic personalities and those with a significant degree of organic structural disease were sometimes subjected to long courses of analytic treatment. In the future there will be no time to waste on the unproductive treatment of such cases, although much may have been, and was learnt by these efforts. Diagnosis as to suitability for psychotherapy is not too easy, and it is in this respect that the non-medical practitioner may find himself at a disadvantage, and so his services may not be so well directed as they ought to be.

Even in the case of the psychoneurotic group so eminently suitable as a whole for psychotherapy, many patients are treated by unnecessarily time-consuming methods, which were much more productive from the research and diagnostic point of view than from the standpoint of therapy. This tendency to unproductive consumption of time from the practical point of view, was still more apparent in the prolonged treatments undertaken by some psychotherapists for the relief of schizophrenic patients.

It is obviously desirable, therefore, to conserve our psychotherapeutic energies and to use them to the best possible advantage. In the first place, if efficient psychotherapy is to be at the disposal of the public, we must consider what sort of people can or should be trained for the purpose of administering this treatment.

It should be realized first of all that it is not every one who will make a successful psychotherapist, however long or ardently he or she may train. The psychotherapist should be sensitive, very patient, possessed of imagination and capable of sympathy. At the same time he must be able to detach himself from the situation, so as to avoid getting too much involved in it himself. He must, while he appreciates the human values of his task, be able to regard it as a scientific problem, the demand for whose solution transcends all other considerations, whether of his own personal feelings or those of anyone else. Such a paragon is not too common in any walk of life and amongst these entering medical schools, the number must, of course, be still more restricted. This is one of the chief arguments of the advocates of lay psychotherapy.

They say that a born psychotherapist will be more successful even without medical training, than the unsuitable person with all the medical training in the world. Indeed, they say, this training in itself may induce a too materialistic outlook and blind the doctor to the spiritual issues involved.

Those who are called upon to select candidates for training, and there obviously should be such selection, may therefore have a difficult and thankless task. Moreover, as Karen Stephen has said, who is to select the selectors and who the selectors of the selectors ?

So far as the training of these doctors who wish to practise psychotherapy is concerned, there is no question but that it is eminently desirable that the candidate for training as a specialist psychotherapist should have a wide knowledge of medicine. He should at least have held a house appointment as a physician and if he aspires to practise child psychiatry a similar pediatric appointment as well. Of the principal training schools for psychiatric specialism, the one demands that its more serious students and research workers should hold the diploma of M.R.C.P., while another, admitting that such a high qualification is desirable, has maintained that the demands for psychotherapy are so great that it is impossible to supply these demands, if such high standards are insisted upon. There is, however, a definite danger in lowering standards too far.

In the future, the candidate will have received a certain amount of instruction in psychology, psychopathology and psychological medicine in his undergraduate years, but he will not thereby be equipped as a specialist. For this purpose prolonged postgraduate training is essential.

It is nowadays considered that anyone who is a candidate for a hospital or public appointment as a psychotherapist should possess the Diploma of Psychological Medicine. The curriculum for this diploma was devised to cover the necessary instruction to fit the holder to treat any sort of mental patient. Already many people consider that while the syllabus covers the necessary basic groundwork, those who wish to take up a special line such as child psychiatry, require even more training, and considerable clinical experience is necessary, of course, before the candidate can consider himself an expert.

It would appear, therefore, that from first to last, in order to become a fully equipped psychiatrist, the aspirant will have to devote about ten years of his life after leaving school.

From the point of view of the patient, given a sufficient supply of competent psychotherapists, the most important requirement is that he should have ample access to treatment. There are many public and private mental hospitals available for the more seriously afflicted mental patients, in which they may receive adequate treatment for their mental illnesses, including psychotherapy. The disadvantage, however, of receiving treatment in such institutions, necessary though it may be in many cases, is that the patient receives his treatment in artificial surroundings. This *milieu* may not fit him for what he ultimately has to do, namely, to adjust himself to the rough and tumble of every-day life. While occupational treatment and rehabilitation may do much to overcome this disadvantage, most psychotherapists are agreed that treatment is most likely to be successful, at least in the case of the psychoneurotics, if the patient can attend as an outpatient and, if possible, carry out his occupation or profession all the time that he is having treatment. For this reason rest homes for nervous patients, sanatoria, etc., while they may be valuable for short periods, when exhaustion or extreme agitation are present, are more likely to serve as a means of escape from the difficulties of life, than as really efficient therapeutic institutions, where the patient may be refitted for the battle of existence, unless treatment is continued for some time after the patient has returned to his home and work.

A large number of outpatients' departments are therefore necessary and many have been started in connection with mental and voluntary hospitals and by local authorities. Many, if not most, voluntary hospitals of 200 beds or over now have psychiatric specialists on their staffs, who do a great deal of work in their outpatient departments, and, as a rule, have a small number of beds allotted to them. It is not generally possible, however, to receive other than quiet and amenable patients into these beds, and they are often filled more for the purpose of research or teaching than for the treatment of those who might benefit most by their occupation.

Outpatient clinics for the treatment of mental illness vary in quality as do any other institutions. Some are little more than reception centres for those about to enter mental hospitals, or follow-up centres for those who have recently been discharged from such institutions. In this they no doubt serve a useful purpose, but what are wanted are clinics at which serious psychotherapy is carried out. There are in existence many of these which serve as a model for what such institutions ought to be, but there are not nearly enough to supply the demand. If patients are to be treated while following their occupations, evening sessions are essential. These are undoubtedly hard on the busy doctor at the end of a tiring day, but they must be arranged, and if one psychotherapist does not have to undertake too many of these late sessions, it should not be too difficult.

Full information as to the facilities for the treatment of adult patients has been compiled by the National Association of Mental Health, and similarly all information concerning facilities for the treatment and disposal of children suffering from mental illness can be obtained from the records of the same body. There is, therefore, no difficulty in finding out what is available for the treatment of anyone of any age, who is suffering from any form of mental trouble, and it is to be hoped that before long many more facilities will be in operation.

By far the greater part of the psychiatric treatment of children is done by child guidance clinics which are available now in most large towns for the outpatient treatment of the 'difficult' child. In the early days of child guidance these clinics were chiefly supported by voluntary contributions, but since their value has been proved, they are now for the most part maintained by local education authorities. Some medical schools run child guidance clinics as part of their service to the community and for teaching purposes.

There is a considerable volume of literature dealing with the child guidance clinic, its constitution and purpose, and a full bibliography of child psychology and psychiatry was prepared by the Child Guidance Council.

Briefly the object of the clinic is to treat the difficult, delinquent and mentally disturbed child, other than the mental

defective, who is catered for by other agencies and in other institutions. The ideal constitution of the staff of a child guidance clinic is a team of three. First the psychiatrist, a medical man or woman, who as a rule acts as director and manages the clinic. He himself undertakes the treatment of the child and when necessary, as it frequently is, of the parent. Second, the educational psychologist, who is concerned with the estimation of the child's capacity in different respects, who advises on any educational problem which may arise. This member of the team may also correct situations relating to school life and in some cases undertakes the special coaching of the backward child, who is not inherently defective. It will be recalled that the backward child is one who possesses a normal capacity for learning, but whose progress at school has been impeded by emotional difficulties. The third member of the team is the psychiatric social worker, who is concerned with the home, the family and the social background of the patient. Her object is to smooth out difficulties and adjust disputes or mismanagement on the part of the parents, which militate against the mental serenity of the child.

All these workers are specially trained, chiefly for child guidance work, though, of course, all may fulfil other duties of their respective professions. In the past this training so far as children's work is concerned has been carried out under the aegis of the Child Guidance Council from its funds, previously derived in large part from generous subsidies by the Commonwealth Fund of America. The Council has been able to offer whole or part-time fellowships tenable at specially selected clinics.

Some clinics exist which lack one or more members of the team, and, although many of these do excellent work, they cannot be regarded as ideal and a child guidance clinic is not complete till it has a full team of at least three.

Attached to many of these clinics, are auxiliary workers such as speech therapists and play therapists. Attention has already been drawn to the importance of play, both in the diagnosis and treatment of the psychoneuroses and emotional disturbances of childhood. Every child guidance clinic should be equipped with an appropriately stocked playroom and one of the team should have made himself familiar with the

principles and practice of play therapy, for a great deal of information useful both in diagnosis and treatment can be obtained through observation and, in certain cases, interpretation of the behaviour of the child. Useful help can of course be obtained from reports of this behaviour when the therapist himself has not the time to spend in the playroom, and a standardized training course for playroom supervisors had been approved by the Child Guidance Council before the war, and after the inevitable interruption of the war years, it has now been found possible to start these courses.

Just as the use of play therapy and the organization of the team shorten the time taken by treatment and increase its efficiency in child psychiatry, certain advances can do the same for adult psychiatry. The team organization is not so far advanced and is not so universally employed in adult work as it is in children's work, and this is a deficiency which it is hoped will be remedied in the future. Already the value of the trained psychiatric social worker is appreciated, not only in getting information about the home and general social *milieu* in which the patient lives and works, but also in modifying these. The social worker can do this by helping to bring to the patient's friends and relations a better understanding of the requirements of the patient and the nature of his illness, so that instead of actively or passively hindering his recovery, as they so often do, they can be got actively to co-operate in his treatment. Again, during and after treatment she can do much to assist him in finding work and in his adjustment in that work and to provide him with opportunities for recreation and leisure occupations.

The role of the psychologist in the child guidance team can also be fulfilled though in rather a different way. One of the chief advances of psychiatry in the war, has been the application of psychiatric and psychological principles on a very wide scale to personnel selection. Between the wars much valuable work had been done on rather a restricted scale on vocational guidance by the Institute of Industrial Psychology, but in the Services not only was it found possible to exclude those who were too mentally backward or emotionally unstable to be of any use in the forces, but also to eliminate

misdirection into employment of those temperamentally unfitted for any particular branch. In this way the individual was undoubtedly spared much emotional conflict, strain and irritation, which would have seriously contributed to a breakdown if they had been allowed to persist. It is obvious that, if such selective methods were applied in civil life to a large section of the working population, much mental illness would be prevented. Moreover, the information gleaned about those who did ultimately require treatment, either previously or at the time of treatment, would be of the greatest service to the psychiatrist and would save him from much expenditure of time and effort.

Various suggestions have been made from time to time for group psychotherapy, whereby several patients could be treated at once. During the 1914–18 war, Good experimented with mass hypnotism but however successful it may or may not have been in his hands, the method has not found favour with others. Again, various schemes have been promulgated from the treatment of 'classes' of psychoneurotics, but these methods have not yet been firmly established, though there may be something to be said for talks to groups of these patients explaining the nature of their illness, the sort of situations which are of causal significance and the general methods used in treatment before individual treatment is begun.[1]

Short cuts have been employed in analytic treatment, the most important of which are the employment of hypno- and narcoanalysis. The restoration of memories under hypnosis has been tried from the earliest times of analytic treatment and while sometimes this has had dramatic results as, for example, in the patient whose recovery first turned the attention of Freud to the possibilities of analysis, the results have

[1] In a recent book (*Group Psychotherapy*, J. W. Klapman. Wm. Heinemann, 1946) the modern methods of group psychotherapy are discussed. Applicable to all forms of psychotherapy and to all forms of mental illness, they are most easily employed in institutional treatment. These methods tend to extrovert the patient and may prepare him to secure greater benefit from individual treatment. It is pointed out that great as is the importance of emotional factors in mental illness the intellectual factors must not be forgotten and they can best be dealt with by group therapy.

not proved sufficiently certain or so lasting as similar results from the more orthodox methods of waking analysis. More promising, however, has been the intravenous administration of narcotics such as sodium luminal to induce a condition of somnolence, in coming round from which the patient can be induced to narrate many unpleasant and harassing experiences, which have proved too painful and terrifying to allow him to bring them to consciousness in a fully awakened state. This method has proved particularly valuable in the treatment of battle neuroses and is certainly useful in the restoration of comparatively recent and not too deeply buried experience, but does not seem to have been as much use in the restoration of really remotely buried memories, which may have to be unmasked and properly integrated in the personality before cure can be achieved.

It has been found that with certain more intelligent patients it may not be necessary to wait for the patient himself to discover, by the laborious process of free association, exactly how his illness was brought about. Given a good positive transference and an experienced psychotherapist who can rapidly sum up the personality of his patient it may be possible to put to the latter certain possible situations for his critical consideration. Of course such propositions may meet with the most strenuous resistance, but the psychotherapist can easily estimate the value of this and indeed it may lead directly to what is being sought. This method allows for more direct give and take between patient and physician and sometimes it transpires that certain conflicts may not be so deeply unconscious as might have been expected.

It is clear that no one method of psychotherapy will suit the personality of every psychotherapist or of every patient. Each psychotherapist will probably work out certain details of technique which suit his own personal genius, although adhering on general lines to one or other school, but he will be wise and more successful if he can modify his technique from patient to patient, according to the requirements of the latter's personality. It is not surprising therefore that the more original the psychotherapist, the more unorthodox are his methods and many books have been written which advocate this or that method of shortening treatment. A good example

is a recent book on active psychotherapy[1] in which it is recommended that from time to time in the course of an analysis the patient should be set ' tasks ' whereby it is hoped he may be led to overcome his difficulties. It is fairly obvious that such tasks will be possible for, and beneficial to, certain patients but not for others and that certain, but not all psychotherapists will have the strength of personality to impose such tasks on their patients.

Advances such as these, however, are in the right direction and are much to be desired in order to shorten the long time taken in any psychotherapeutic treatment and to make the whole process rather more coherent.

Whatever facilities are afforded for the treatment of adults or children by psychotherapy, these will not be fully effective unless they are associated in the closest possible way with a hospital concerned with the diagnosis and treatment of physical illness. The hospital clinics have this great advantage that they form part of the services rendered by an institution which covers and provides for all types of disease and has at its disposal for this purpose all the facilities of general wards, laboratories, radiological and physiotherapeutic departments.

The necessity for all these facilities again raises the vexed question of the lay psychotherapist, who would not find himself so readily able to estimate when it was necessary to obtain the help of medical colleagues, or to work so closely with them, if only because they would not be members of the same team and would not speak quite the same scientific language.

Apart from a few trainees of the Psychoanalytic Society, the chief claimants to competence in the practice of lay psychotherapy are the academic psychologists and certain of the clergy.

The psychologists claim that psychotherapy involves the practical application of psychology and of education, especially in the case of children and, while they acknowledge that some medical specialists have an adequate knowledge of psychology, they argue that the majority have had no real training in the subject. Without this, they hold, these medical practitioners have no sound knowledge of the normal mind and so can hardly

[1] Herzberg, A. *Active Psychotherapy.* 1945. London.

be successful in understanding and treating the abnormal mind. Apart from this, they argue that there is so much demand for psychotherapy, that all who are in any way competent to practise it, should be drawn into the service and they seem confident that they would have no difficulty in recognizing the occurrence of any organic disease, when they could call in medical advice.

The clergy who wish to undertake psychotherapy belong chiefly to the Anglican and English Free churches. In evidence given before a special committee which was investigating the subject, the representatives of the Roman Catholic Church and the Church of Scotland declared that their ministers, if they carried out their proper duties conscientiously would have no time to practise psychotherapy.

The argument of those clergy who think that they should practise psychotherapy, is that many of the problems which call for such treatment are spiritual rather than material and therefore the province of the priest rather than of the physician. Like the psychologists they say that if they encounter organic disease in the course of the treatment, they can refer the patient to a doctor for the necessary treatment.

They further say that many doctors not only have no special knowledge of the spiritual life of the patient but are so opposed to the spiritual point of view that they may do the patient a very great deal of harm by causing serious emotional conflict in the religious sphere, in the process of attempting to cure other conflicts. There is no doubt that there is truth in this contention and the future must decide whether there is more risk run by the patient in receiving psychotherapy from a doctor ignorant of theology or from a parson ignorant of medicine. The exchange and combination of knowledge is obviously of the highest importance, but again the difficulty of the long time taken in a double training by any one individual may prove to be an unsurmountable obstacle.

The purpose of this book has been to survey not only the potentialities of psychotherapy, but also its limitations and to show how important it is to consider the patient as a whole, giving full attention both to the physical and mental aspects of his personality. It is also pointed out that physical disease

often simulates mental disturbance and how still more often mental illness results in symptoms only distinguishable with difficulty from those caused by true structural changes. If this presentation is accepted it is a very strong argument for the view that only those with a wide medical knowledge are likely to be safe and competent psychotherapists. In view of this it is often maintained that if laymen are to be trained as psychotherapists, and thoroughly trained they must be, this training will be so lengthy that they might just as well take a medical degree and be done with it.

Some medical practitioners argue, however, that there can never be enough medical psychotherapists to meet the demands and that therefore lay psychotherapists should be recognized, provided that they work in conjunction with, and as auxiliaries to, medical psychotherapists. In this way the latter would be able to exercise some control and prevent the 'wild psychotherapy' that does so much to discredit the whole business of psychological treatment.

There is much cogency in this argument, and if there are to be lay psychotherapists, which may very well be necessary if the demand is to be met, it may be that the correct procedure is that proposed by an important body of would-be clerical psychotherapists who have approached the medical profession, asking them to arrange an appropriate course of training for them. The object of this course would be to fit them to act as medical auxiliaries having the same sort of status as masseurs and radiographers. They would undertake to work only under the direction of a medical psychologist and would be prepared to refer the patient back for review as often as seemed desirable. The difficulties inherent in such a scheme would be to devise a course of training, which did not take too long and to ensure the loyalty of all concerned to the principles of the auxiliary group. However, no doubt these difficulties could be overcome.

The organization of psychotherapy should then be based on adequate training of suitably selected candidates, on team work, and on wide co-operation with those skilled in all branches of medical knowledge. Psychotherapy should only be employed moreover, in the case of those patients who can be effectively treated by these means.

There can be no question but that academic psychology, philosophy and possibly religious teaching all have a significant contribution to make to medical psychology, and they should not be neglected in any scheme for the better organization and further extension of service to those who require this form of treatment to restore them to health.

CHAPTER XIV

THE COMBINED APPROACH

THE most hopeful signs in modern medicine are a return to the treatment of the sick patient, instead of the disease from which he suffers, and the tendency to team work in practice. If we are to carry out treatment efficiently we cannot afford to neglect any aspect of the patient's personality. We must think of his mind, we must think of his body, but we must also think of him as a social being in relation to his environment, both personal and material, and this social factor is, perhaps, most important in the prevention of disease, which is so much more to be desired than even its cure.

Success in treatment, however, is not only dependent on the doctor, especially if the treatment takes the form of psychotherapy. The first person who must lend a hand is the patient himself, for everyone knows how difficult it is even in the case of gross physical disease to treat the non-co-operative patient; in fact, until he has become co-operative, treatment will not progress very effectively. In this respect, however, the psychotherapist has a grave responsibility. It is not enough for him to say, 'This patient is non-co-operative, he doesn't give me a chance to treat him, it is his fault, there is nothing more to be done!' It is perhaps an exaggeration to say that it is more often the doctor's fault than the patient's, if the latter does not come willingly for treatment, but there may be truth in some such statement, if the patient is suffering from severe emotional disturbance. In such a situation he will be frightened, sensitive, or even aggressively shy. It is the business of the doctor to determine, if he possibly can, why the patient cannot or will not co-operate and, in the case of the psychoneurotic, to resolve the difficulty or to hand the patient over to someone who can do so. In the psychotic, however, the case is different. In the confusional state the

patient cannot collect his thoughts sufficiently to co-operate ; in the elated state he thinks himself far too well or too wise for such co-operation to be necessary ; in the depressed phase he is far too ill or too unworthy to do so, while in the schizophrenic state, his world of phantasy is so all-important that the effort of the physician to bring him back to reality is an impertinence or worse. Such people, if the condition is sufficiently severe, cannot be got to co-operate, and the psychotherapist, if he has genuinely satisfied himself that his diagnosis is correct, is justified in abandoning the struggle, at least so far as psychotherapy is concerned, though other methods of treatment may be both necessary and beneficial. In fact we may say it is the duty of the psychotherapist not to accept the non-co-operative psychotic for treatment by psychotherapy, though he may supervise and reinforce other methods of treatment, since, with the present shortage of psychotherapists, his services are urgently required to treat those who can benefit by his skill.

Of course, the psychoneurotic, especially the hysteric, does not, at first at any rate, wish to abandon his illness, through which he obtains semiconsciously, or perhaps it would be fairer to say unconsciously, many advantages. It must be realized, however, that this unwillingness to abandon the illness is an important symptom of that illness and one calling for considerable effort to cure. In such cases successful treatment depends on the establishment of an adequate transference which is one of the principal ' arts ' of psychotherapy.

Even when there is an advantage in the illness the patient knows in his heart of hearts that his symptoms are an unsatisfactory compromise, and it is because this knowledge is there, however much overlaid, and because it can by psychotherapy be brought into full consciousness that it is possible to treat the hysteric as well as those suffering from the other forms of psychoneuroses. In the psychotic this belief either does not exist, or is difficult or impossible to bring to light, and this accounts for the difficulty in the treatment of these patients.

Next in importance to the co-operation of the patient, is that of the relatives and friends of the patient, who, in the

case of the psychoneurotic at least, are apt to be very hostile to the psychotherapist. For some reason the friends seem to think, either that the patient is not really ill, or if he is, that they ought to be able to cure him themselves or rather be able to persuade him to cure himself, though they would never think so in respect of other illnesses. They are consequently annoyed when they find themselves unable to do so. Being unwilling to admit that the failure was due to their own lack of knowledge, they blame the patient and resent the intervention of a stranger who may go so far as to suggest that they themselves are not guiltless for the production of the illness they have wished to cure. They are therefore often intensely suspicious of the psychotherapist. They don't like these new-fangled ideas, they are afraid that he will exert some sort of influence on the patient from which the latter will not be able to escape. They think that the doctor will obtain an undue ascendancy over the patient, a fear which may be apparently justified for a time in the phase of strong positive transference. They do not realize, however, that this transference must be resolved before the treatment is complete. Finally, they may be afraid that the psychologist may lead the patient into all sorts of generally quite imaginary and ill-defined shameful practices (mostly sexual).

Such an attitude of the relatives must hinder treatment, for it either produces divided loyalties, which of course increase emotional conflict and disturbance, or it may cause the patient to feel hostile to his relations, with possible future feelings of remorse and guilt, or on the other hand he may feel hostility to the doctor and so he may break off treatment.

The only remedy for this state of affairs is to educate the public to a better understanding of mental hygiene and a greater appreciation of what the psychotherapist is trying to do. Such education is proceeding actively at the present day, by means of lectures and books and occasional broadcasts, but this in itself may have a danger, for the ill-informed public may swing to the opposite extreme, as a few indeed have already done and, instead of regarding the psychotherapist with hostility and suspicion, may tend to attribute to him magic powers and expect him to achieve results which are beyond the scope of mortal man. Or again, they may think

that attendance at a few lectures qualifies them to practise the most intricate forms of psychotherapy themselves.

It is here that the family doctor, who is the third essential member of the team which must help the specialist, can do so much to allay the suspicions of the patient himself and his relatives. He must of course get rid of his own prejudices and know enough about mental medicine to recognize when his patient is in need of specialist help. He must be prepared when necessary to persuade his patient to put himself under the care of a psychotherapist whom he can trust, just as he does when he judges that his patient requires the services of an operating surgeon.

If the co-operation of the patient and his friends can be obtained through the good offices of the family doctor, the psychiatric specialist and general practitioner must work together. The specialist must not unnecessarily exclude the practitioner from the treatment of his patient and he must realize that the role of the practitioner is of the very highest importance. Not only must the latter be able to recognize when the patient is in need of highly technical treatment, but he ought to be able to undertake the treatment of the simpler cases himself so as to leave the specialist time to do justice to the more difficult cases. It was said in the first chapter that every successful doctor since the days of Hippocrates had practised psychotherapy, but something more than this is required, he must practise his psychotherapy not only unconsciously and *malgré lui*, he must know what he is doing and how to deal with his patient along certain definite scientific lines.

This is not the place to discuss changes in the medical curriculum and improvements in teaching methods, for this has recently been dealt with at great length by various committees set up to advise the General Medical Council in connection with the future of medical education. It is not too much to say that all who have given real thought to the subject are agreed that there is a need, a crying need, for more, much more, teaching of ' the mental side of medicine ', both to the undergraduate and the graduate.

This demand does not come only, or even chiefly from graduates and still less from teachers, each of whom is inclined

to regard his own speciality as of paramount importance. There is a strong demand from students, in spite of the already great length of the curriculum, for more psychological teaching. If this demand is satisfied, there will be fewer doctors who hinder the cure of the patient, in exactly the same way as do unsympathetic relatives, by inducing divided loyalties and a general uncertainty and emotional distress.

However much undergraduate teaching is given, the general practitioner will not become a specialist, he cannot nowadays know all about everything. If the treatment of any given patient is beyond him and he refers him to a specialist, he must play his own part in helping on the treatment, by carrying out the recommendations of his colleague and trying to adopt toward the patient an attitude, which will enhance the influence of the latter and promote the success of the treatment.

Co-operation must also come from the general physician and from specialists in other branches of medicine. Perhaps as a result of competition, perhaps as a result of a false pride based on a feeling of insecurity, such people are unwilling to admit that the diagnosis and especially the treatment of the psychoneuroses may be outside their province and competence. This dog in the manger attitude is no longer met with between the physician and the surgeon, for the former will readily admit that he is not competent to open the abdomen, or the head, though the converse humility of the surgeon with regard to medical treatment is not always so obvious.

On the other hand, it is not unusual to hear general physicians say that they are quite as competent to treat the mind as they are the body. If this were only true of the majority of physicians, tremendous advances in medicine might be just round the corner, for there would be a real combined approach to the patient, but, alas, it is not true. Nowadays, surgeons claim that the mind is a suitable field for their exploitation and certain surgical operations such as prefrontal leucotomy seem likely to have a permanent place in the treatment of certain illnesses. But such operations are not to be undertaken casually and we must not let our patients believe that ' this is the operation which cures worry '. It is essential that neurosurgeons should, as the best of them are

doing, become thoroughly efficient psychiatrists, as well as neurologists, and work in close conjunction with psychotherapists. Again there is no doubt that removal of septic foci and other sources of toxic poisoning and of certain parts of endocrine glands, such as the thyroid, pituitary and adrenals which are secreting excessively or abnormally, may result in amelioration of mental symptoms in certain cases.[1] Such successes in specially selected cases must not, however, lead to an expectation of universal success in all apparently similar cases. For example, certain distinguished and enthusiastic oto-rhino-laryngologists have been heard to announce with complete confidence that they can cure all cases of depression by clearing out the sinuses. If this were so, there would certainly be no need of psychiatrists.

It is unfortunately true that many of the general physicians and non-psychiatric specialists are even less aware of the need for psychotherapy and less appreciative of the skill of the psychiatrist than are the majority of general practitioners. It may be admitted that some of the criticism which comes from these leaders of the profession is well founded, for there are bad psychotherapists and wild psychotherapy in plenty. But there are also bad physicians and worse surgeons, but fortunately these unskilled and often dishonest practitioners of all branches of the profession are not representative of the faculty of medicine as a whole. The very vehemence of the denunciations of the unfortunate psychiatrist which are voiced by some members of the profession, however, betokens ignorance and prejudice rather than considered judgment, but on the whole the psychiatrist is much more fairly treated now than he used to be a few years ago.

The good physician must always be constantly alive to the psychogenic factor in diseases. He must be continually on the watch lest he attributes to irreversible structural change, conditions which are still reversible, but not by drugs and potions or even by electricity and magnetism. The general physician has not the knowledge, time or skill to do everything and just as he would not dream of trying to perform a difficult surgical operation or to delay its application, if he thought it was for the benefit of his patient, so let him not attempt or

[1] Cf. Broster, L. R. 1944. *Endocrine Man*, pp. 105–107. London.

delay the application of difficult psychiatric treatment, which only the skilled specialist can perform.

The psychiatrist is not, however, himself without blame for the same sort of mistake. Either he is blind to his own limitations, or he is not sufficiently skilled in general medical diagnosis, to recognize physical disease when he sees it. Yet it will often happen that he will get more satisfaction and even kudos from recognizing a condition which is outside his province, and sending the patient where he can obtain the best attention, than from the successful treatment of one of his own brand of patient.

Many physical conditions produce syndromes which appear to be purely psychogenic in origin, and no doubt do owe much of their nature to psychological reactions to organ inferiority of one sort or another. This makes it all the more important to carry out a thorough physical examination of every case, especially if such symptoms as progressive fatigability, muscular wasting and loss of weight are prominent. Severe anxiety conditions do involve much expenditure of energy and wasting of tissue, and these symptoms may be very prominent in some of the psychoses, but their occurrence must make the psychiatrist very careful that he does not miss some underlying growth or severe infection or endocrine anomaly which is ' liberating ' psychological reactions which might or might not have been manifest without the physical illness, but which in any case are of minor importance when compared to the lethal influence of the physical disease. Sloan[1] has quoted two cases of lung tumours with multiple autonomic disturbance whose symptoms were, with considerable justification regarded as purely functional. The point is that it is right and proper that the psychotherapist should be called in to deal with such abnormal psychological manifestations, but, if he is not entirely satisfied that he is on the right track, he must not hesitate to send the patient back to the general physician for further investigation.

Medicine is too complex nowadays for one individual to be the universal specialist, so team work is imperative. General practitioner, physician, surgeon and psychiatrist each have their respective roles to play, and in all conscience there is

[1] Sloan, LeRoy H. 1945. *Med. Clin. N. Amer.*, p. 30.

plenty of work to be done in each of these roles. So let each specialist be willing to stick to his own last and refrain from trespassing in the other's province, though they must co-operate to the very best of their ability. All may profitably work together along with special experts, such as the pathologist, the radiologist and others in a combined approach to the patient and in a combined attack on ill-health, whether this occurs in the individual or in the community.

Nor must the ancillary services be forgotten ; they may play an essential and by no means a humble part in the diagnosis and treatment of disease. In psychiatry the psychologist, the psychiatric social worker and the occupational therapist are not used half enough. Although their help is being sought in the mental hospital, in the child guidance clinic and in the mental treatment clinic, they are not yet being employed in private practice to any extent. If the mental patient is to be properly treated either private practice must give place to clinic treatment, a development attractive in some ways, but with obvious disadvantages, perhaps especially in psychotherapy, where the privacy of the patient is so important, or some scheme must be devised whereby the private patient gets equal advantages with the clinic patient.

More important than treatment, however, is prevention, and better teaching is required to enable all concerned, including the relatives of the patient, to recognize difficulties and departures from normal behaviour, before they become illnesses. At the same time it is necessary to recognize the root causes of both mental and physical disease and teach the world how to eradicate them. So far as mental illness is concerned perhaps the most important requisites are to teach people that nothing is to be gained by insensate competition for non-essentials and that sex is a normal function of the body which can be discussed unemotionally and which does not need to be treated as if it were an esoteric mystery. In both these directions the medical profession could be of great assistance in the education of their patients and through them of the community at large.

There are many vistas of progress opening up before medicine at the present time and research in every branch offers opportunities for epoch making discoveries. The further

afield that each branch goes however, the more obvious it becomes that the world of man is round and not flat. All divergent paths should, and indeed must, meet to enclose a whole individual with no part unrelated to another. It follows therefore that both prevention and treatment must also be directed to all the factors comprising that whole, the internal and the external environment. Hereditary, constitutional factors, physical and mental trauma and disease and the social *milieu* must all be considered and dealt with, before the causation of disease can be determined or complete treatment be effected. Good housing, proper nutrition, adequate recreation and opportunities for the advantageous use of leisure are essential pre-requisites for health.

The future of medicine is set fair to be greater than its past, the value of health and the importance of social services are in the forefront of all plans for reconstruction. There is work, masses of work, and sufficient reward for all those who are seriously determined to undertake that work. Let us then have done with mutual suspicions and jealousies, the team's the thing, let us get together in a combined approach, with one object and one object only in view, the material and spiritual welfare of the whole human race and where necessary because illness has already intervened, the rehabilitation of the individual patient in relationship with the world around him.

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